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ALL AGAINST AIDS

STRATEGIES FOR HOPE No 7

The Copperbelt Health Education Project, Zambia

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ALL AGAINST AIDS

The Copperbelt Health Education Project, Zambia

By V. Chandra Mouli

STRATEGIES FOR HOPE: No. 7

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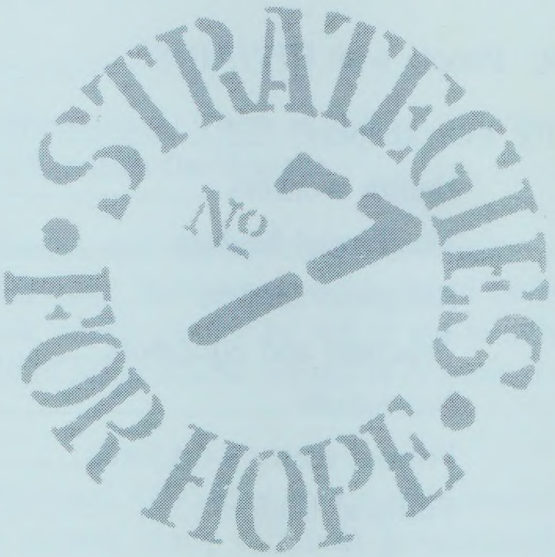

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Foreword

AIDS is a health problem of truly global dimensions. There is still no cure for AIDS and no vaccine against HIV, the virus which causes the disease.

AIDS is primarily a sexually transmitted disease, and the key to its prevention is behaviour change. In order to change their behaviour, however, people need both information and support. Providing these is a task which cannot be left to the health services alone, but requires the active involvement of all available means of communication and social organization.

Ever since its inception in 1986, Zambia's National AIDS Prevention and Control Programme has fostered a spirit of cooperation among many different government institutions and non-governmental organizations (NGOs). We have found that NGOs can identify and respond quickly to unmet needs within the community. They are particularly well placed to develop flexible, innovative strategies and programmes in response to the many challenges posed by the AIDS pandemic.

In this book, Dr V. Chandra Mouli describes how one of Zambia's leading NGOs, the Copperbelt Health Education Project (CHEP), has developed a multi-pronged approach to AIDS prevention. *All Against AIDS* will be of great interest and practical value to policy makers and programme managers, health practitioners and social workers, community and religious leaders, teachers and educators, groups of people with HIV and AIDS, and many other individuals and community groups. I warmly recommend it to everyone involved in the struggle against AIDS.

Dr B.U. Chirwa
Health Education Specialist
Ministry of Health
Lusaka, Zambia

Preface

In 1982, when I first arrived in Zambia, AIDS was virtually unknown. The first cases had been officially diagnosed only 12 months earlier, in the USA. It was not until 1985 that the first case of AIDS was officially identified in Zambia.

Today, AIDS is recognised as a public health problem of enormous proportions, not just in Zambia but worldwide. It is a disease with a uniquely devastating impact, not only on health but on all aspects of family and community life.

My training was in clinical medicine. I felt confident of my ability to diagnose and treat a wide range of diseases. As long as the prescribed treatment was available, patients would generally recover. But AIDS was different. Here was a fatal, infectious disease for which there was no cure and no vaccine. Like many other health professionals, I felt increasingly frustrated by the impotence of modern medical science in the face of HIV, the virus which causes AIDS.

Finally I decided to abandon clinical medicine, which I had practised for several years in the town of Kitwe in Zambia's Copperbelt, and to devote myself instead to the prevention of AIDS. Together with a few close friends and colleagues, and with support from the National AIDS Prevention and Control Programme and NORAD, I formed the Copperbelt Health Education Project (CHEP).

This book is a brief, personal account of CHEP's first four years of involvement in the struggle against AIDS – our achievements, our failures, our frustrations and our hopes for the future. *All Against AIDS* describes what we have learned, through experience, about how to help rally many sections of the community to combat AIDS, how to empower individuals to protect themselves against the disease, and how to provide care and support to people living with HIV or AIDS.

I have tried to keep the language used in this book as non-technical as possible, but have had to use some specialist terminology. The book therefore includes a glossary of key communication and medical terms.

I am particularly indebted to Father Frank Carey for the information about religious leaders in section 10, and to Sister Lynn Walker for drafting section 15. I would also like to convey my special thanks to Mrs Birgitta Soccorsi, Dr Kristina Baker, Dr Narayan Rao and officials of the Zambian Ministry of Health for their tremendous help and encouragement.

Finally, I would like to share the credit for producing this book with all my colleagues at the Copperbelt Health Education Project. We hope that others may find our experiences relevant and useful in the global struggle against AIDS.

V. Chandra Mouli

1 June 1992

1. Introduction

In the 1980s a new pandemic – AIDS (acquired immune deficiency syndrome) – emerged as a threat to the health, development and survival of millions of individuals, families and communities throughout the world.

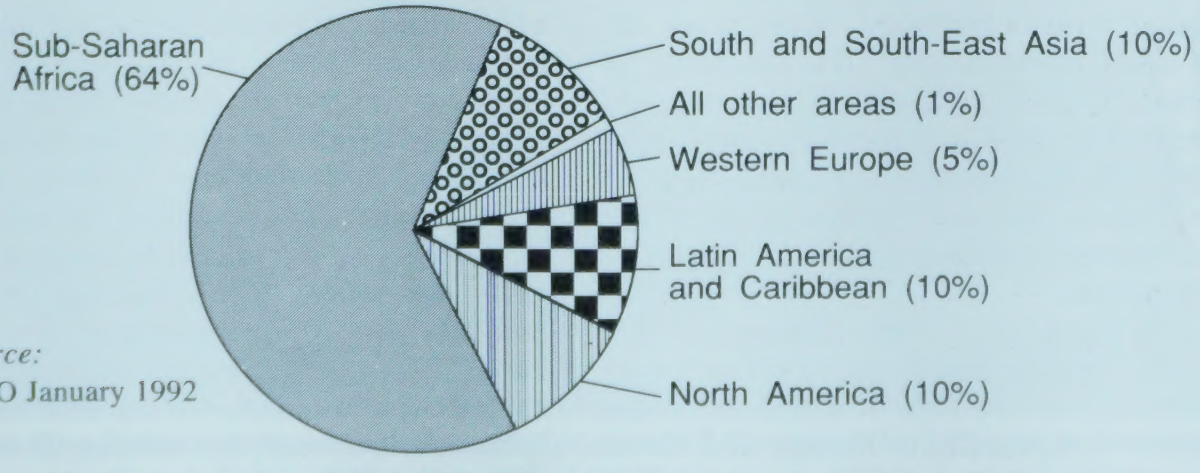
By early 1992, according to the World Health Organization's Global Programme on AIDS, an estimated 9 to 11 million adult men and women worldwide were already infected with HIV (human immunodeficiency virus) – the virus that causes AIDS[1]. Women infected with HIV have given birth to about 1 million HIV-infected children. Worldwide, the number of adults and children who have already developed AIDS is estimated at about 2 million, many of whom have already died.

WHO predicts that, by the year 2000, a total of 30 to 40 million men, women and children worldwide will have been infected with HIV. By the end of the 1990s there will be over one million adult AIDS cases a year, the great majority in the developing countries of Africa and Asia.

The number of children who lose one or both parents through AIDS is expected to increase more than tenfold during the current decade. WHO estimates that, by the year 2000, there will be 10 to 15 million 'AIDS orphans' worldwide, most of them in sub-Saharan Africa.

The countries of sub-Saharan Africa are bearing the main brunt of the AIDS pandemic (Figure 1). In this vast region, where HIV is spread mainly through sexual intercourse between men and women, at least 6.5 million adults and nearly 1 million children are already infected with the virus. In parts of East and Central Africa, child mortality rates – which had been greatly reduced over the past few decades – are starting to rise again because of AIDS.

AIDS is systematically undermining the health, economic and social infrastructure of countries throughout sub-Saharan Africa. The health costs of the epidemic are already substantial and constantly rising. In large urban hospitals in East and Central Africa, for example, 30-50% of all hospitalized patients suffer from AIDS-related illnesses. But the direct costs of coping with AIDS will be dwarfed by the indirect costs of the epidemic, as it makes inroads into both the urban and the agricultural workforce, eroding economic productivity and family incomes. In many places the clan and extended family system, which for centuries has been an effective coping mechanism in times of crisis, is being steadily weakened by AIDS.



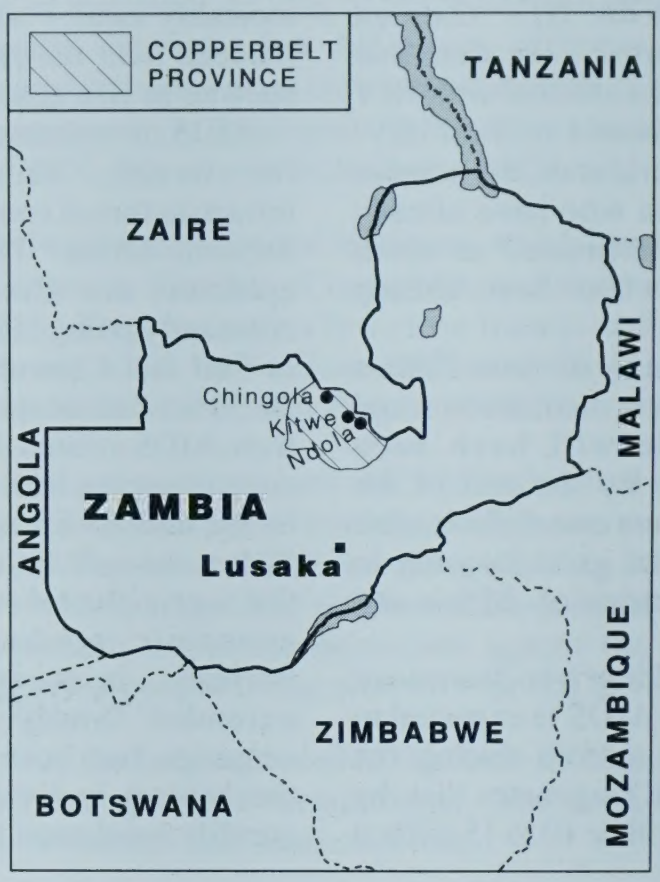
Source:
WHO January 1992

Figure 1: Estimated worldwide distribution of HIV infections in adults

2. The case of Zambia

With over half its population of 8 million living in towns and cities, where the level of HIV infection is about twice that in rural areas, Zambia will suffer the full impact of the AIDS pandemic sooner than many other African countries.

By 31 December 1991, Zambia had reported 5,803 cases of AIDS to the World Health Organization[2]. Yet these figures fail to convey any idea of the scale of HIV infection and the impact which AIDS will have on the economy and on family and community life in Zambia during the 1990s and into the twenty-first century.



It is likely that one in five of sexually active Zambians in urban areas is already infected with HIV. The virus is widespread in rural areas as well. Recent surveys have identified HIV infection in 13-24% of pregnant women in rural and urban areas, and 18-23% of healthy blood donors at major hospitals[3]. Most, if not all, of those infected with HIV are likely to develop AIDS within the next five to ten years. The great majority are young adults with dependent children, who will be orphaned before completing their schooling and being able to fend for themselves.

During the mid-1980s Zambia was still in the 'age of denial' of AIDS as a real problem. In the face of scores of media stories – especially in Europe and North America – blaming Africa for the AIDS pandemic, virtually all African governments reacted defensively by denying that AIDS was a problem in their countries. This led to official inactivity and loss of precious time, allowing the epidemic to spread unabated.

In 1986, however, the Zambian Ministry of Health officially recognized AIDS as a public health problem, and AIDS education activities were started later that year. A broad coalition, consisting of the Health Ministry's Health Education Unit and several non-governmental organizations, produced a stream of posters, booklets, pamphlets, newspaper messages, radio and television broadcasts – all aimed at teaching the public the basic facts about the new disease.

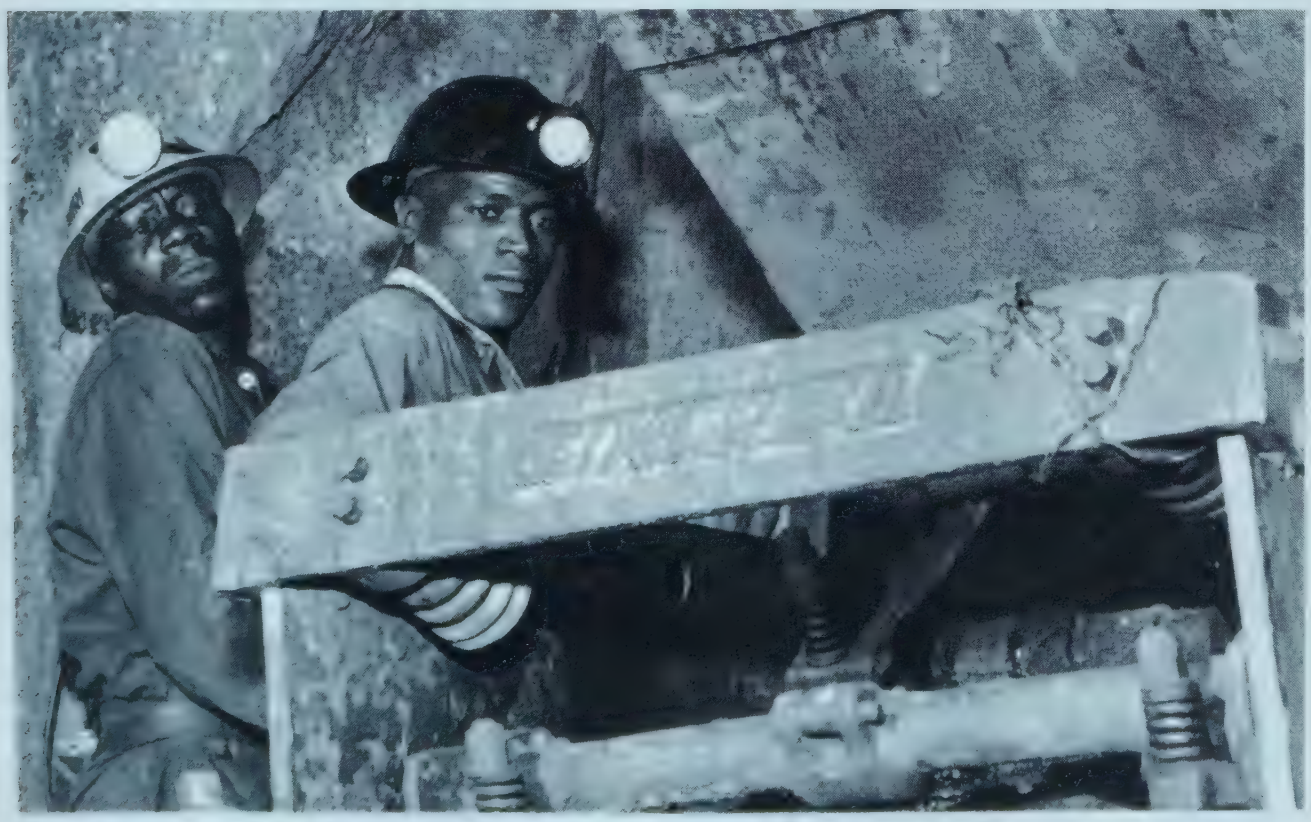
This, then, was the 'age of information' in the development of official and public responses to AIDS. Health education efforts were launched, based on the assumption that information would empower people to protect themselves against HIV and thus prevent the spread of AIDS. Several years later, however, there is a growing awareness that information alone is not enough to prevent the spread of HIV and AIDS. The challenge of the 1990s is not only to provide information about AIDS, but also to promote and support the attitudes, values and sexual behaviour necessary to curb the spread of HIV and AIDS within the community.

3. Local setting

Zambia's Copperbelt, one of the country's nine Provinces, is the nation's economic heartland. Massive slag heaps in and around the towns testify to the region's long history as a major mining centre. Copper produced in the region accounts for about 80% of Zambia's export earnings, and the Province's largest employer, Zambia Consolidated Copper Mines, is one of the largest corporations of the African continent.

With about 2 million inhabitants, the Copperbelt has 25% of Zambia's total population. Since Zambia achieved independence in 1964, there has been a massive influx of young people from rural areas looking for work in the Copperbelt's mines, factories and service industries. At the same time, many Copperbelt residents, on reaching retirement age, have returned to their places of birth in other parts of Zambia or neighbouring countries. As a result, a high proportion of the population of the Copperbelt is in the sexually most active age group of 18 to 45 years.

The rapid urbanization of the Copperbelt has been accompanied by the break-down of traditional values and codes of behaviour, the weakening of extended family ties, and increased levels of alcohol abuse, crime, violence and commercial sex. In addition, for the past decade the economy of the Copperbelt – along with that of the country as a whole – has been beset by a severe recession, resulting in increased unemployment, lower incomes and declining public services. The combination of these factors has created a social and economic environment which facilitates the spread of sexually transmitted diseases, including HIV infection. The levels of HIV infection within the population of the Copperbelt are believed to be among the highest in the country.



The Copperbelt is the most densely populated Province in Zambia, and copper mined in the region accounts for about 80% of the country's export earnings.

4. Project origins and development

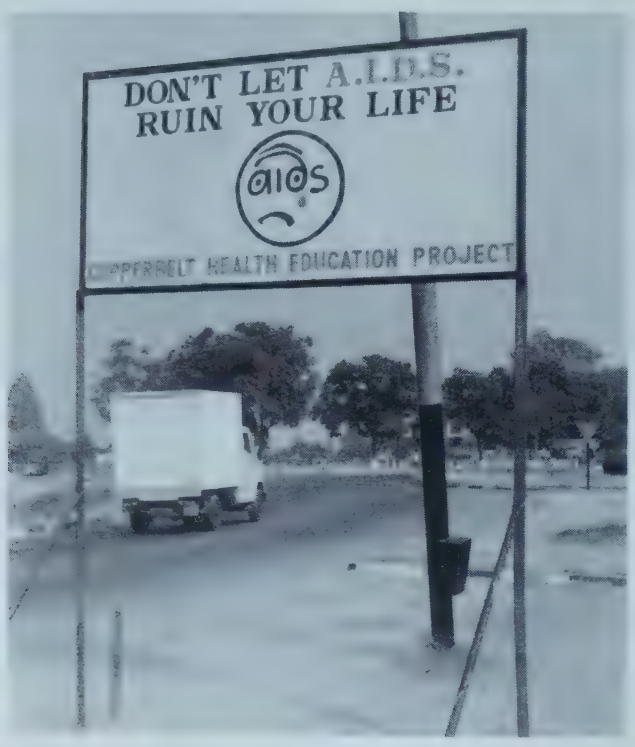
The Copperbelt Health Education Project (CHEP) began in January 1988. Apart from myself as Coordinator, our only other staff member was a High School graduate who helped with fieldwork. Our office was located in a spare room in my flat in Kitwe, and our equipment consisted of a couple of desks, a few chairs, a filing cabinet and a manual typewriter.

My own professional background scarcely qualified me to set up and run a health education project which aimed to help prevent the spread of AIDS. My medical training at Hyderabad in India had concentrated almost entirely on clinical medicine. In Kitwe, I had worked as a general practitioner for four years, and then spent nine months as Coordinator of the Kitwe Nutrition Group, which was my first experience of public health work. Towards the end of this latter period I also began to produce posters and leaflets on AIDS, as well as giving talks on the subject to groups of health workers.

CHEP's main aim was to help prevent the spread of AIDS by raising public awareness of the dangers of the disease, and by providing people with information about how HIV is transmitted and how they could protect themselves and others against it. Our work was based on the assumption that ordinary people, once informed about the disease and how it is spread, would be able to make the necessary changes in their sexual behaviour. We have since realized that this assumption was somewhat simplistic, but it seemed reasonable at the time.

CHEP began its existence, not as an organization in its own right, but as a social service project of the Kitwe North Branch of the Rotary Club. Rotary is a highly respected international organization involved in a wide range of social service activities, and this arrangement helped to make CHEP more acceptable to the local authorities and members of the public.

Our funding – for an initial period of one year – was provided by NORAD (the Norwegian Agency for Development



Roadside billboards – part of CHEP's early campaign to reach as wide an audience as possible.

Public litterbins were also used to convey messages, although the negative skull and hearts symbol has since been dropped.

Cooperation), after our budget and plans had been approved by the Provincial Medical Officer and the National AIDS Prevention and Control Programme.

We did not leap immediately into the production of educational materials. Our first step was to establish a ten-person Advisory Committee chaired by Dr Narayan Rao, Head of Surgery at Kitwe Central Hospital, to provide guidance on policy matters. We then set about forging strong working links with the Copperbelt Provincial AIDS Surveillance Committee, and also with the Committees in each of the eight Districts in the Province.

In the middle of 1988 we produced our first printed materials – 130,000 copies of a leaflet about AIDS for primary school children, and 50,000 copies of a booklet aimed at secondary school children. Both were based on publications already produced by the Anti AIDS Project, a Zambian NGO which distributes educational materials through its network of over 700 Anti AIDS Clubs throughout the country.

This was the start of what could be called the 'shotgun approach' phase of our work. We tried to reach the widest possible audience with information about AIDS through posters, roadside billboards, leaflets, newspaper advertisements, T-shirts and flipcharts. We set up information booths at local fairs, organized a national AIDS song contest, and sponsored drama groups. Dr Rao and I appeared on radio and television shows, and we spoke to groups of teachers, religious leaders, journalists, health workers and political leaders. It was a time of hectic, intense activity on many fronts.

In October 1988 we broke away from the Rotary Club and registered the Copperbelt Health Education Project as a non-governmental organization in its own right. We also moved into our own office, provided at a nominal rent by a member of the local business community, and employed a secretary. Two months earlier we had taken on Mr Shaddy Chondoka, a trained clinical officer, as Deputy Coordinator of the Project. Over the 12 months from October 1988 to September 1989, while I was on study leave in the U.K., Mr Chondoka was in charge of the day-to-day running of the Project.

5. The need for support

By the end of 1989, after CHEP had been running for almost two years, our surveys showed that the general public of the Copperbelt Province was well aware of AIDS as a serious health problem. Significant numbers of people, however, still harboured misconceptions about how HIV is transmitted. Our surveys showed, for example, that one in four people believed that AIDS could be spread by mosquitoes.

There was also no evidence that people were changing their sexual behaviour as a result of greater awareness and knowledge about AIDS. Indeed, according to the National AIDS Prevention and Control Programme, the level of HIV infection among blood donors in the country's main towns and cities increased by 3% annually between 1987 and 1989[4].

It also seemed likely that some of our messages (e.g. **AVOID AIDS – AIDS KILLS!**), combined with the use of WHO's skull and hearts logo (withdrawn in 1989), had the unintended effect of leaving many people anxious, afraid and even angry because they were unable to respond effectively to the threat posed by AIDS to their own health and survival. Such messages may also have reinforced the negative feelings already harboured by many people towards those already infected with HIV.

During the first six months of 1990 we grappled with three fundamental questions:

- If information alone is not enough to prevent HIV transmission, what more is needed?

- Given that large numbers of people are already infected with HIV, is it acceptable to focus our efforts solely on the prevention of HIV transmission?

- In view of the close links between AIDS, tuberculosis (TB) and sexually transmitted diseases (STDs), should we widen the scope of our programme to include TB and STDs?

As far as the first question was concerned, we concluded that, in addition to knowing the basic facts about AIDS, people also required the motivation and self-confidence to act upon this information. They therefore needed the *support* of a social environment in which safer sexual behaviour* is made easier by being viewed as socially acceptable, and high-risk sexual behaviour is made more difficult by being viewed as unacceptable. In addition, in order to change their behaviour, many people also needed access to services such as professional counselling, HIV antibody testing and treatment of STDs, and to supplies such as condoms.

With CHEP's limited resources, it was obviously impossible for us to provide all these forms of support, services and supplies on the scale required. We therefore decided that we would aim to identify, inform, mobilize and support all available means of communication and social organization, as well as all care-givers and leaders of public opinion, in a multi-pronged effort to combat AIDS within the community.

We also concluded that AIDS messages based on fear served to strengthen the stigma associated with AIDS, thus discouraging people from coming forward for testing or admitting their HIV status to their sexual partners. We therefore decided to avoid messages based on fear and instead to promote positive values and attitudes – especially responsibility towards one's family, and the need for respect and compassion towards people living with AIDS within the community.

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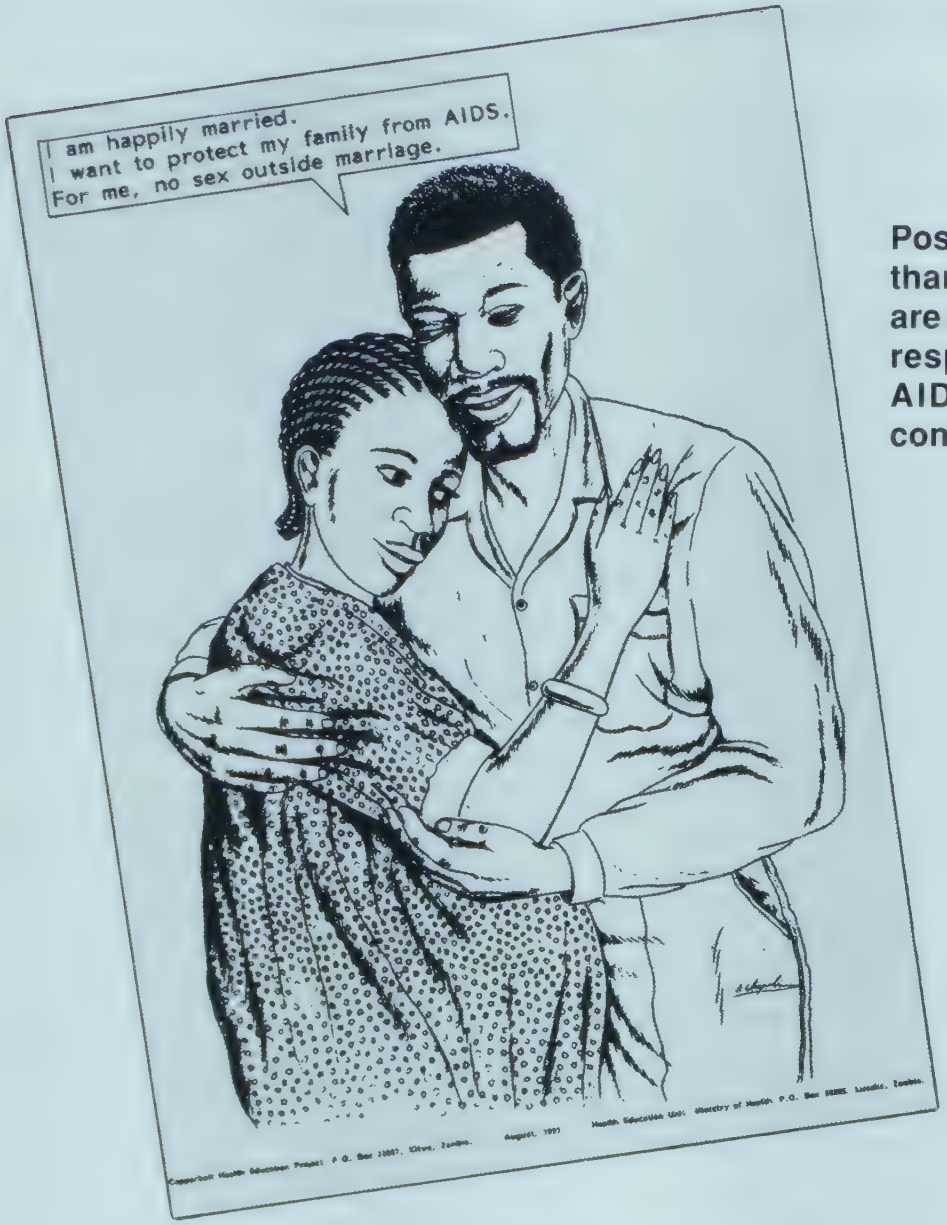
*For definitions of 'safer' and 'high-risk' sexual behaviour, please see Glossary.



Positive messages – rather than those based on fear – are more likely to promote responsible attitudes to AIDS prevention and control.

The second and third questions we faced were closely linked. After long and careful consideration, we decided to broaden the scope of our programme to include the control of STDs and tuberculosis. This would have three advantages. First, it would introduce some variety into our work and also reduce the chances of over-saturating the public with AIDS information. Second, given that people with STDs are extremely vulnerable to contracting and transmitting HIV, it could also make a real contribution to reducing the spread of HIV/AIDS. And third, it could help deal with the alarming increase in the incidence of TB among people with HIV/AIDS, and also help prevent the spread of TB within the community*.

* In countries such as Zambia, where TB is endemic, most babies contract TB germs early in their lives. In most cases, however, the body's defence system is able to prevent the TB germs from multiplying and causing serious damage. The TB germs remain in the body, but in a dormant state. However, if the body's immune system is weakened – for example, through HIV infection – the germs multiply and spread to various parts of the body, causing active disease. Most people with HIV/AIDS in Zambia also develop TB, and may become active transmitters of TB germs within their families and the community.

6. 'Know your audience'

When CHEP started, in 1988, our aim was to provide simple, clear and accurate information about AIDS, in order to create public awareness and understanding of the dangers of the disease and so help prevent its spread within the community. The task at hand seemed very clear to us. The basic facts about AIDS had already been established by the World Health Organization. Our responsibility was to make these facts available to the maximum number of people in the shortest possible time. To achieve this, we used newspapers, radio, television, posters, roadside billboards, information booths at fairs, street theatre performances, drama and song contests to disseminate information about HIV and AIDS to the general public.

With the benefit of hindsight, we now realize that during this phase of our work – which lasted for just over a year – our approach was basically "We tell, you listen". We devoted very little time to understanding the needs or responses of those for whom the materials were intended. We did not even 'pre-test' the materials we produced, and this of course resulted in problems. For example, we produced several hundred copies of a flip chart which included a line drawing of the cross-section of a pregnant woman's abdomen to illustrate how HIV can be transmitted from mother to baby in the womb. This drawing was perfectly understandable to doctors, but quite unintelligible to a group of women's leaders with whom we tried to use it during a training workshop.

We therefore began to ask ourselves whether our 'messages' were being heard, understood and acted upon – and if not, why not? To try to find some answers, we began to enter into a process of two-way communication with the public. In early 1989, for example, we set up a write-in advisory service, which soon resulted in a regular stream of letters revealing common worries and misconceptions about AIDS. One of the most common questions was "Do mosquitoes spread AIDS?" In response to this clear demand for information, we prepared a simple, one page statement, put it on stencil and duplicated it in large quantities for distribution.

A second way in which we became more sensitive and responsive to the needs of the public was through direct, interpersonal contact. This was possible, for example, through question-and-answer sessions during workshops and teaching sessions for groups such as college students, health workers, journalists, church groups, traditional healers, out-of-school youth and other groups. From the hectic, two-way communication that took place in these sessions we became increasingly aware of what people in these various groups already knew about AIDS and how they felt about the disease. It also became clear that there were large and important differences from one group to the next concerning their members' knowledge, concerns and fears about AIDS. We concluded that we would have to tailor the contents and presentation of our materials to the knowledge, concerns and fears of particular audiences – or 'target groups' – rather than to the public in general.

A third way in which we have gained a much better understanding of our target groups is through systematic surveys of their knowledge, attitudes and behaviour. In the second quarter of 1990, for example, we developed a booklet entitled *What Everyone Should Know about STDs*. Before starting work on the booklet, we conducted 'focus group' discussions with three different groups – white collar workers, manual workers, and college

students – who represented the main target groups for the booklet. These discussions helped us to identify the most common beliefs, knowledge gaps and misconceptions among these groups concerning STDs. Using this information, we prepared a list of issues to be covered by the booklet, as follows:

- What are STDs?
- Why are STDs dangerous?
- Who can get STDs?
- How are STDs spread?
- How can a person know if he or she has an STD?
- What should a person do if he or she has an STD?
- How can STDs be prevented?

Next, we developed sets of short, clear statements about each of the above issues. The ball was then in the court of our artist. We gave him all our text messages, with brief descriptions of the drawings that would best illustrate the messages. When the rough drawings were ready, we moved into the 'pre-testing and revision' phase. We invited two members from each of our three target groups, none of whom had participated in our original focus group discussions. We then interviewed one person at a time, following the guidelines set out in the manual *Developing health and family planning print materials for low-literate audiences* published by PATH[5]. In each session a picture was presented and the person was asked:

- "What do you see in the picture?"

The accompanying text was then presented and the person was asked:

- "What do the words mean to you?"
- "How do you feel about the picture and the words?"
- "What would you change?"

The respondent was allowed to talk freely without interruption, and his or her comments were noted. We followed this procedure for all six respondents.

This was in fact the first time that we had pre-tested any materials in such a systematic way. We had thought it would be just a formality, and that as soon as it was finished we would be able to dash off to the printers. How wrong we were! We were simply amazed at the numbers of perceptive comments we received. Humbled, we went back to the drawing board and revised both the drawings and the text. Only after two more rounds of pre-testing and revision, and after obtaining the approval of the Ministry of Health's National STD Control Programme and the Health Education Unit, was the booklet finally ready to go to the printer.

We now realize that understanding the audience (or target group) and involving them in the process of designing health messages and materials is the key to successful health education. When planning any new materials, we first ask ourselves five basic questions:

1. To whom (i.e. to which target group or groups) are the materials directed?

2. What behaviour are we trying to change, and in what way?

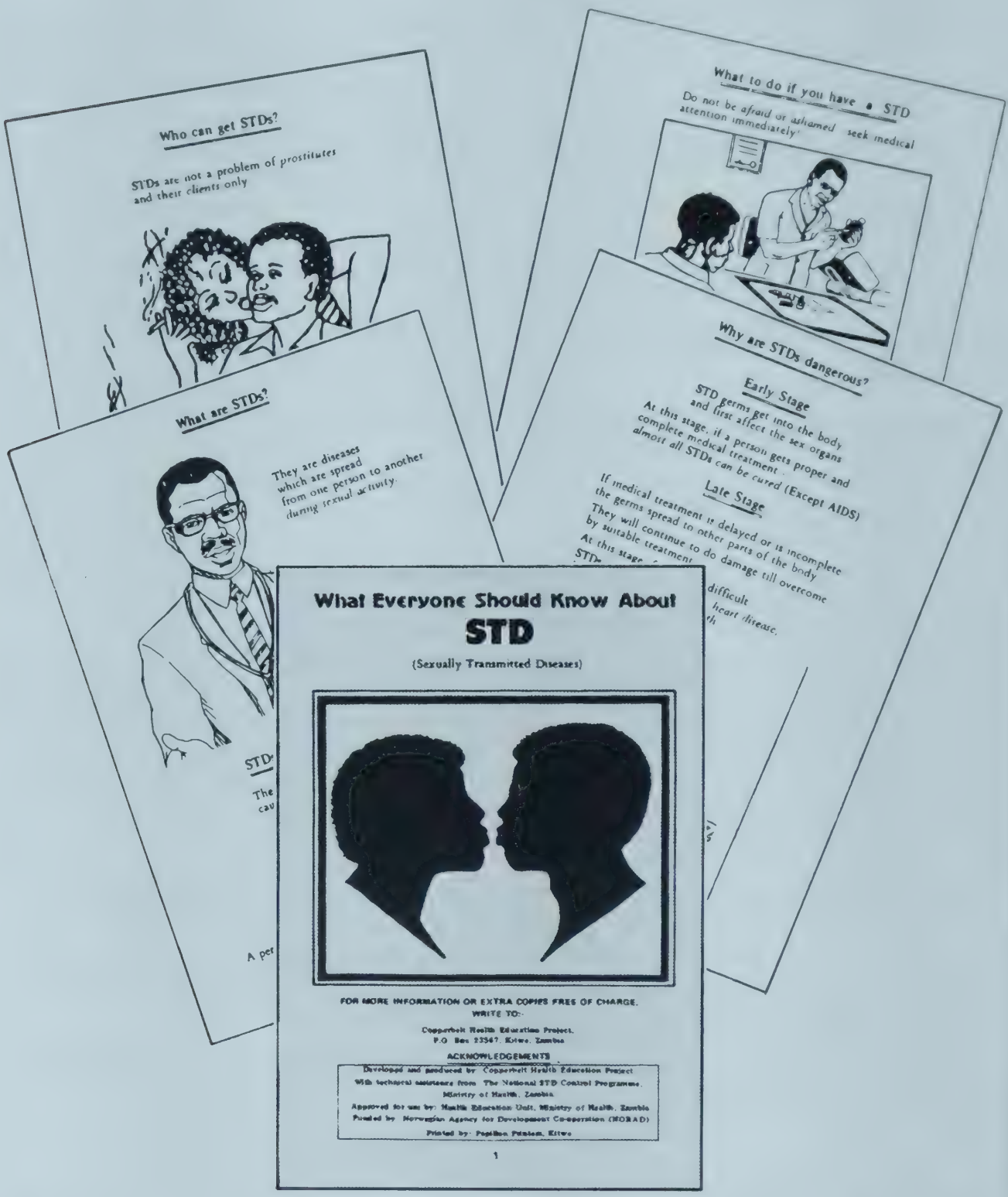
3. What information does the target group require?

4. What emotional appeal will be most likely to strike a chord with the target group?

5. Through which communication

channel, or combination of channels, can the information be communicated to the target group?

The responses to these questions determine the contents and presentation of the materials, and the ways in which they are disseminated to the various target groups whose knowledge, attitudes and behaviour we are trying to influence.


Who can get STDs?
STDs are not a problem of prostitutes and their clients only
What are STDs?
They are diseases which are spread from one person to another during sexual activity.
What to do if you have a STD
Do not be afraid or ashamed seek medical attention immediately!
Why are STDs dangerous?
Early Stage
STD germs get into the body and first affect the sex organs
At this stage, if a person gets proper and complete medical treatment almost all STDs can be cured (Except AIDS)
Late Stage
If medical treatment is delayed or is incomplete the germs spread to other parts of the body
They will continue to do damage till overcome by suitable treatment
What Everyone Should Know About
STD
(Sexually Transmitted Diseases)
FOR MORE INFORMATION OR EXTRA COPIES FREE OF CHARGE, WRITE TO:-
Copperbelt Health Education Project,
P.O Box 23547, Kitwe, Zambia
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Printed by: Papillon Printers, Kitwe
1

Materials, such as this booklet about sexually transmitted diseases, are pre-tested with a variety of audiences, and revised accordingly before going to print.

7. The general public

A large part of our work consists of education aimed directly at our first 'primary target group', the general public, with three main objectives in mind:

- To increase knowledge and concern about HIV and AIDS
- To promote safer sexual behaviour and thus help reduce the sexual transmission of HIV
- To encourage respect and compassion for people living with HIV/AIDS in the community.

To reach the general public, we use a wide variety of communication channels, including the mass media, 'small' media, special events and our own 'walk-in, phone-in, write-in' information service.

Mass media

Radio, television and newspapers reach a sizeable and influential audience in Zambia. A recent survey in the Copperbelt and Northern Provinces, for example, found that 58% of the population listens regularly to the radio[6]. Television reaches a relatively small, but highly influential, audience living mainly in urban areas. The two main national newspapers, *Zambia Daily Mail* and *The Times of Zambia*, have a combined circulation of 100,000. When CHEP carried out a survey of 296 adults in two townships in Kitwe District in 1989, we found that 66% of people said they read newspapers and 52% regarded newspapers as one of the best ways of informing the public about AIDS[7].

We have made extensive use of the mass media. For example, we have placed 'spots' with AIDS prevention messages on television, and produced a weekly radio programme, 'Health is Wealth' (in English and Bemba) on health-related topics. For some time we placed weekly advertisements with challenging, even provocative, AIDS-related messages in the main newspapers and magazines. We have also used the press to advertise competitions and special events, as well as our services and educational materials.

There has been so much mass media coverage of AIDS in recent years, however, that we now use the mass media more selectively, and with a view to entertaining as well as educating the audience. In 1991, for example, we produced a 13-part series of 30-minute television programmes, in English, called 'Talking AIDS'. The series was aimed at middle class, white collar workers who are decision-makers and opinion leaders in their professional and social networks. Broadcast at peak viewing time on Monday evenings, each programme began with a 5-10 minute episode of a 'soap opera' about a Zambian family affected by AIDS. This was followed by a lively discussion by a panel of community members (factory and office workers, mine employees, teachers and students, housewives and religious leaders) and one or two health workers.

We have found that the public responds very well to the publication of our illustrated booklets in newspapers. In June-July 1990, for example, we serialized our booklet *What everyone should know about STDs* in the daily *Times of Zambia* and published the whole booklet in one issue of the fortnightly *National Mirror*. The response was dramatic. Our office was flooded with letters (over 1,000 per month) from people requesting copies of the booklet or asking for additional information about STDs.

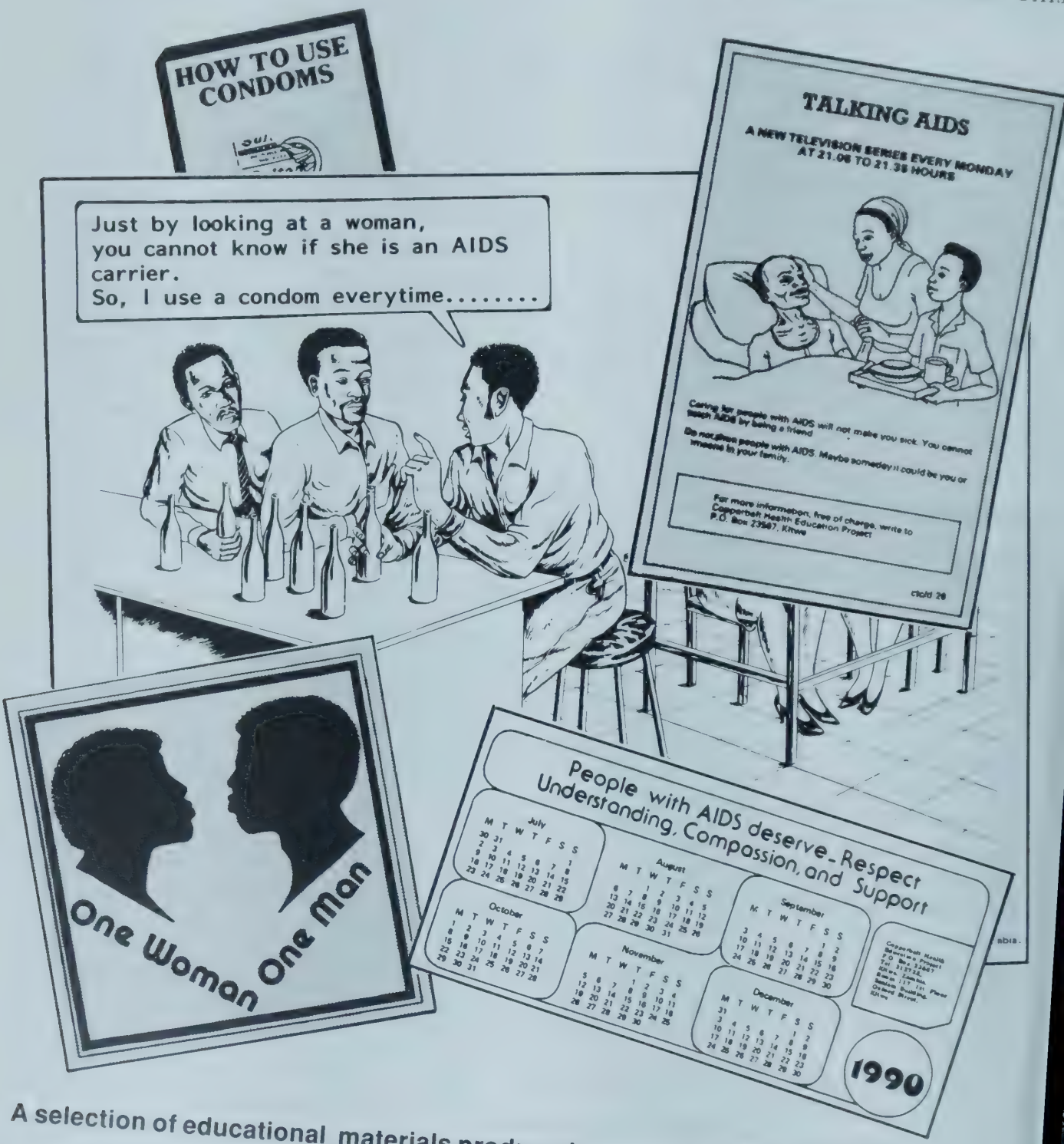
'Small' media and special events

We have used a very wide range of 'small' media and special events. These include, for example:

Booklets such as *Information on AIDS for Adult Men and Women*, and **leaflets** such as *How to use condoms*

Posters, roadside billboards, dustl carrying messages such as "For a l and healthy life, drive safely and l carefully"

Slips of paper with brief AIDS messag distributed at public functions (e World AIDS Day, World Health Da and along with household water bills


HOW TO USE CONDOMS
Just by looking at a woman, you cannot know if she is an AIDS carrier.
So, I use a condom everytime.....
TALKING AIDS
A NEW TELEVISION SERIES EVERY MONDAY AT 21.05 TO 21.35 HOURS
For more information, free of charge, write to Copperbelt Health Education Project P.O. Box 23567, Kitwe
One Woman One Man
People with AIDS deserve - Respect Understanding, Compassion, and Support
1990

A selection of educational materials produced or sponsored by CHEP.

Calendars incorporating AIDS and health messages

T-shirts with AIDS prevention messages (discontinued because too expensive)

Street theatre in townships, followed by a question-and-answer session

Drama contests for young people organized in cooperation with the Catholic Diocese of Ndola

Song contests and a **record** featuring the song 'One Woman, One Man'

Exhibitions of cartoons, photos and paintings on AIDS-related themes

Financial support for public rallies (e.g. on World AIDS Day) organized by the District and Provincial AIDS Committees

Stands and **video shows** at exhibitions and fairs.

All these media provide opportunities to reach particular population groups with basic information about AIDS, to promote safer sexual behaviour, and to encourage respect and compassion for people with HIV and AIDS.

Information and advisory service

To respond to the queries and concerns triggered by our public information campaigns, we provide a free 'walk-in, phone-in, write-in' information and advisory service, staffed by Mr Shaddy Chondoka, an experienced clinical officer who is also a trained AIDS counsellor. Only a limited number of people (about 20-30 per month) visit the CHEP office or use the telephone to request information or discuss their problems. Over 5,000 people a year, however, write to us for information. About half of these live in the Copperbelt Province, and the overwhelming majority are men. This is probably because men have had more opportunities to become literate and so have easier access to newspapers than women.

Mr Shaddy Chondoka with some of the thousands of letters asking for information which the CHEP office receives annually.

8. Vulnerable groups

Some sections of the population, because of their sexual behaviour, health status, occupation or socio-economic situation, are at greater risk of contracting – and spreading – HIV than others. CHEP has identified four such 'vulnerable groups':

- members of the security forces
- bar workers and their customers
- STD clinic attenders
- out-of-school youth.

We have made a special effort to inform and educate these groups about how they can protect themselves against AIDS. At the same time, we have been careful to avoid directing public attention to them because this can lead to resentment and victimization, and can also foster a sense of false security among others. We have therefore concentrated on reaching these groups with information that is clear, factual and non-judgemental – usually through 'small' media and inter-personal communication rather than through the mass media.

Security forces

Members of the Army, Air Force, Police and National Service are more likely to become infected with HIV than many other sections of the population. They are often posted away from their families for long periods of time in different places, and are thus likely to have more sexual partners than the general population. Being in receipt of a regular income, they are better able to purchase sexual favours. They are also more likely to come into contact with HIV-infected blood, for example from wounded or injured colleagues, or from people involved in road traffic accidents.

In working with the security forces our aims are three-fold:

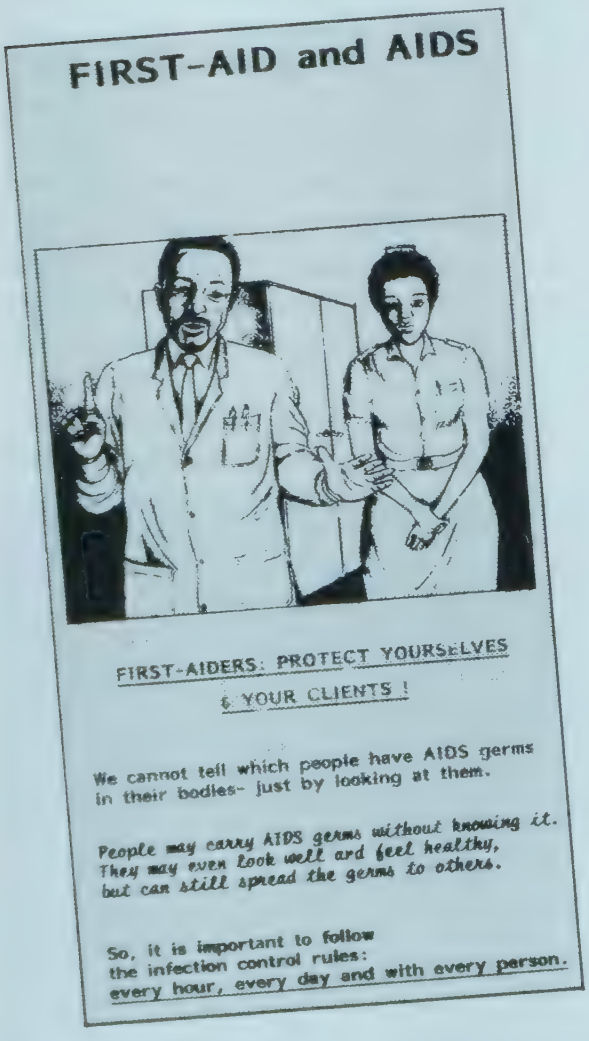
- to increase their knowledge and concern about AIDS and other sexually transmitted diseases
- to motivate change to safer sexual behaviour
- to promote safer first-aid practices.

We began by holding AIDS seminars for officers and medical personnel from the various branches of the security forces, and also gave talks to groups of recruits. Initially we found it difficult to stimulate discussions at such meetings, which were probably too large for frank, open talk about sexual matters.

We also made a systematic distribution of our booklets and leaflets about AIDS, STDs and condoms to every military camp and every police station in the Copperbelt. In addition, we wrote to all commanding officers for permission to come and speak to groups of officers and men. For some time, there was little response. Some officers seemed to feel insulted by the idea that special attention was being paid to security forces where AIDS prevention is concerned. Their attitude seemed to be: "Why are you accusing us of being more promiscuous than others?"

We found that one way of dealing with

this objection was to open the dialogue by mentioning the risk (relatively small) of a member of the security forces contracting HIV infection from the blood of an injured colleague or an accident victim. After establishing a degree of rapport by tackling a non-controversial issue about which they were already concerned, it was easier to discuss the far more sensitive – and more


FIRST-AID and AIDS
FIRST-AIDERS: PROTECT YOURSELVES
& YOUR CLIENTS !
We cannot tell which people have AIDS germs in their bodies- just by looking at them.
People may carry AIDS germs without knowing it. They may even look well and feel healthy, but can still spread the germs to others.
So, it is important to follow the infection control rules: every hour, every day and with every person.

Extract from a leaflet written for first-aiders.

serious – issue of contracting HIV through sex. Members of our Outreach Team – including military personnel – are now being invited to run AIDS seminars and training sessions for groups of officers and men within military camps. These meetings are quite lively, with a great deal of questionning and discussion.

Bar workers and customers

Many Zambians go to bars and taverns* simply to enjoy a drink and a chat with friends after work or at weekends. Many people, however, also go to drinking places expecting – or at least mentally prepared – to make contact with casual sexual partners. In a country such as Zambia, where prostitution is illegal, bars and taverns are in fact the most popular places for 'picking up' casual sexual partners.

Truck drivers, travelling salesmen and businessmen, security force personnel and young, unmarried men are only some of the groups for whom drinking alcohol and casual sex go hand-in-hand. Many family men in stable marriages go drinking on pay-day and, under the influence of alcohol, have sex with a woman – often a bar or tavern worker – in exchange for cash. Only rarely is a condom used in these casual sexual encounters. Bar and tavern workers, and their customers, are therefore at high risk of contracting sexually transmitted diseases, including AIDS.

In the first half of 1990 we distributed a Ministry of Health AIDS poster and our booklet *Information on AIDS for Adult Men and Women* to over 200 bars, taverns, hotels, clubs and restaurants in Kitwe and Kalulushi Districts. Our target group at

*In Zambia a 'tavern' is a drinking hall serving locally brewed millet beer.

this time consisted of the workers, not the clients, of these drinking places. After six months we carried out a survey of 100 bar and tavern workers and found that 95% were afraid of getting AIDS, but they complained that there was nobody with whom they could discuss their concerns and fears face-to-face. In response to this finding, we decided to change our programme strategy. We retrained our field workers in person-to-person communication skills, and began to combine the distribution of printed materials with direct, interpersonal communication.

The approach now followed by our fieldworkers is to start a conversation, either with an individual or a group, using our *Information on AIDS* booklet as a stimulus for discussion. Other bar or tavern workers often join in, and a lively interchange of opinions takes place. Since our fieldworkers make their visits during the day, when business is quiet, the managers or owners rarely object to their staff spending some of their working time in this way. The response of the bar and tavern workers themselves is usually open and friendly, though they are often sceptical – for example about whether condoms are effective in preventing AIDS – and doubtful whether they could persuade their clients to use condoms.

Our initial contacts with bar and tavern customers, however, were not encouraging. We found, for example, that many of the Ministry of Health posters we distributed in the first half of 1990 were quickly defaced or torn down by irate customers. And whenever customers joined in the discussions with bar or tavern workers, tempers flared and chairs, tables and – occasionally – even heads were thumped.

Nevertheless, in December 1990 we decided to target bar and tavern customers

Using posters and leaflets as visual aids, a CHEP worker explains the risks of contracting AIDS to a group of tavern customers.

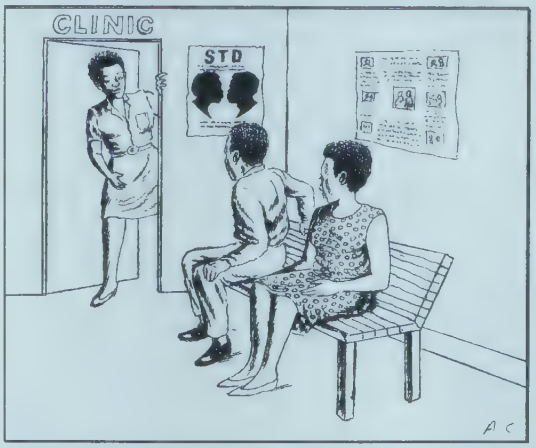
with information about AIDS. Two of our most experienced fieldworkers began systematically to visit all the most popular drinking places in the town of Kitwe. However, they encountered two serious problems. First, they were unable to meet many customers because their visits took place only during daylight hours. (For security reasons, it was not feasible to send our fieldworkers around the drinking places at night.) Second – and more importantly – whenever they did meet groups of customers, all too often a fierce, unproductive argument developed.

After a couple of months we decided to reassess the situation. Through 'focus group' discussions in three bars, we concluded that many bar and tavern customers simply did not want to talk or even think about AIDS, especially when they were out to relax and have a good time. To these people, our fieldworkers were simply a nuisance, an unwelcome intrusion. We therefore decided to suspend this programme for a few months.

In mid-1991 one of our fieldworkers started meeting again with small groups of bar and tavern workers and their clients, using the booklet *Information on AIDS for Adult Men and Women* as a talking point. He also distributed two new posters: one promoting the positive values of faithfulness in marriage and responsibility towards one's children, and the other advocating the use of condoms by those who decide to practise extra-marital sex. Although the work is difficult, tempers have not flared to the same extent as before.

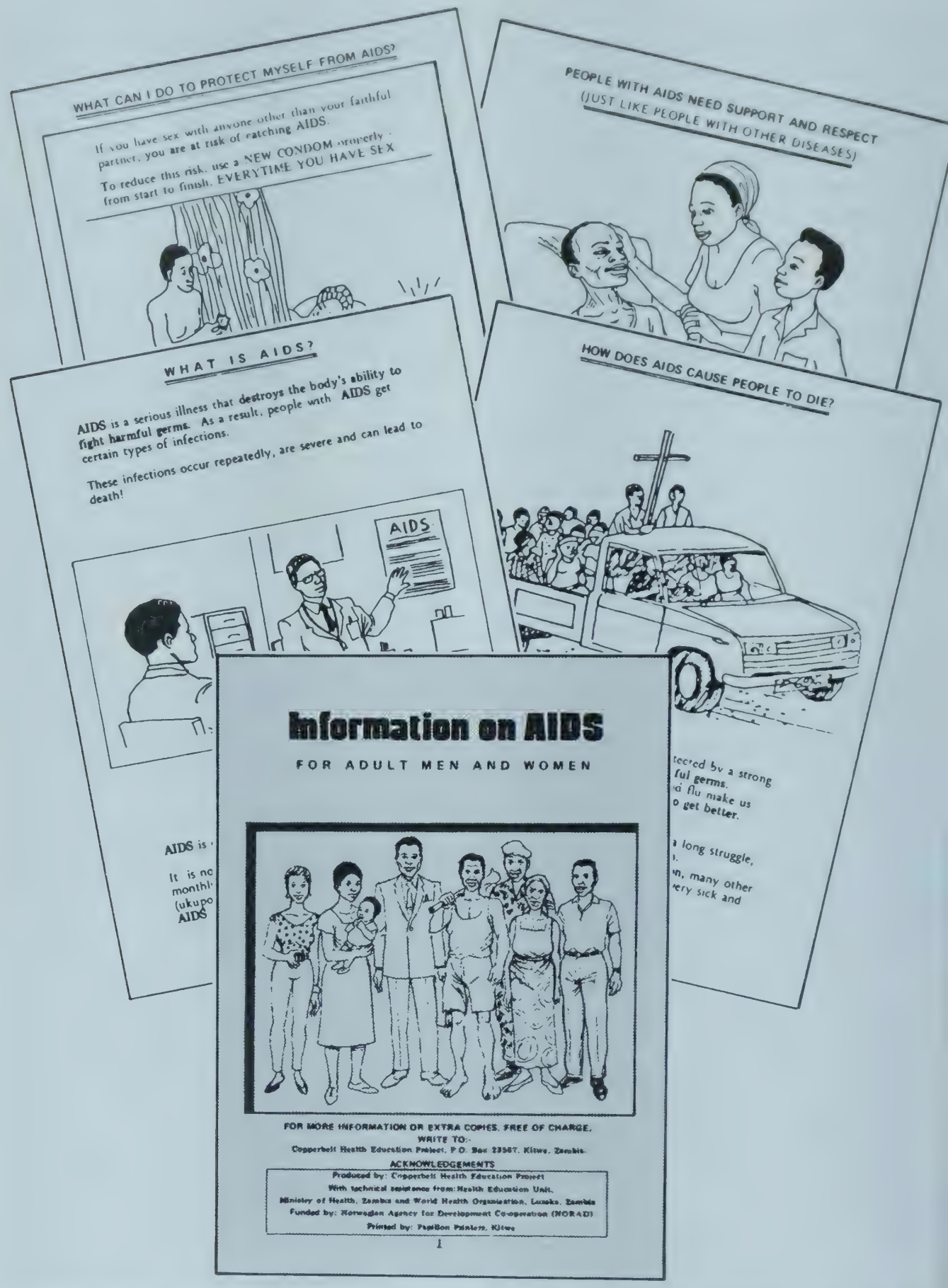
We are currently undertaking a 'Knowledge, Attitudes and Practice' (KAP) survey on condom use by bar clients in Kitwe and Chingola. Preliminary findings indicate that members of this important target group still need much more education and support for behaviour change. Although 58% of clients surveyed knew that condoms, if properly used, provide a high level of protection against AIDS, 54% said that condoms had more disadvantages than advantages. One in every three clients claimed to have used a condom in the past six months, but only 12% did so on every occasion they had sex.

STD clinic attenders



Men and women who seek treatment for suspected sexually transmitted diseases (STDs) are a very important target group for AIDS education. If infected with an STD such as a genital ulcer, they are at much greater risk of contracting – and transmitting – HIV to their sexual partners. Effective diagnosis and treatment of STDs can therefore help to reduce the sexual transmission of HIV. But it is equally important to provide STD clinic attenders with the information and support they need to protect themselves and their sexual partners against HIV infection.

The STD clinic itself is a uniquely favourable setting for promoting safer sexual behaviour. People who seek treatment for suspected STDs implicitly admit – to themselves and to the health worker – that they have engaged in high-risk sexual behaviour. They have put themselves at risk, and they know it. They may feel afraid or ashamed, angry or sad, but all will feel vulnerable. Those diagnosed as having an STD will feel particularly open to advice at the moment they are informed of their condition. This is psychologically the most favourable time to communicate with them about how to avoid becoming infected again.


WHAT CAN I DO TO PROTECT MYSELF FROM AIDS?
If you have sex with anyone other than your faithful partner, you are at risk of catching AIDS.
To reduce this risk, use a NEW CONDOM properly from start to finish. EVERYTIME YOU HAVE SEX
PEOPLE WITH AIDS NEED SUPPORT AND RESPECT
(JUST LIKE PEOPLE WITH OTHER DISEASES)
WHAT IS AIDS?
AIDS is a serious illness that destroys the body's ability to fight harmful germs. As a result, people with AIDS get certain types of infections.
These infections occur repeatedly, are severe and can lead to death!
AIDS
HOW DOES AIDS CAUSE PEOPLE TO DIE?
Information on AIDS
FOR ADULT MEN AND WOMEN
FOR MORE INFORMATION OR EXTRA COPIES, FREE OF CHARGE, WRITE TO:-
Copperbelt Health Education Project, P.O. Box 23587, Kitwe, Zambia.
ACKNOWLEDGEMENTS
Produced by: Copperbelt Health Education Project
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Printed by: Pamilion Printers, Kitwe
1

Information on AIDS for Adult Men and Women **is one of CHEP's most widely distributed booklets.**

In 'targeting' STD clinic attenders we have two main objectives:

- To increase their knowledge and concern about STDs and AIDS

- To motivate them to adopt safer sexual behaviour.

Since we in CHEP do not provide health care, we are able to reach this target group only indirectly, through health workers who operate STD clinics. We have therefore made a particular effort to produce and disseminate materials about the diagnosis, treatment and prevention of STDs.

Our booklet *What everyone should know about STDs*, although aimed at the general public, is widely used by health workers. We have also produced an *STD wallchart* which depicts, in diagrammatic form, the management protocols for the five most common sexually transmitted diseases in Zambia. The chart translates the results of clinical research into a form which is readily useable by a nurse or clinical officer in a busy Outpatient Department or health centre, or by a doctor working in private practice. We introduce the chart in AIDS workshops and have distributed copies to every hospital and health centre in the Copperbelt. The National STD Programme has distributed copies to health institutions in other parts of the country.

Our focus group discussions for the STD booklet also yielded some important information about the attitudes and behaviour of health workers towards people attending STD clinics. A number of people who had been treated for STDs at public clinics complained that they had received scoldings from health workers in the presence of other patients. This would obviously deter them from seeking treatment for STDs in the future.

To help rectify this situation, we prepared a set of simple guidelines to assist health workers in using the STD booklet in brief, 'one-to-one' counselling sessions. We have introduced these guidelines to health workers during sessions on communication skills at AIDS workshops. Doctors, nurses and clinical officers perform role plays and so learn how to practise giving (and receiving) health information in a more tactful, understanding and effective manner.

Out-of-school youth

Like many other developing countries, Zambia has a large number of out-of-school youths earning a precarious living in the 'informal' sector of the workforce. Throughout the Copperbelt, thousands of young men survive by selling cigarettes, sweets or newspapers on street corners; others work as small traders or mini-bus touts; some become petty black-marketeers or criminals. Many young women work as house servants or nannies, others as bar workers or nightclub hostesses.

All these young people are at high risk of contracting HIV. Young women are particularly vulnerable to pressure from 'sugar daddies' to provide sexual favours in exchange for gifts or cash. Young men, for their part, are exposed to strong peer pressure to experiment with alcohol, drugs and sex.

These young people are difficult to reach with information about AIDS through institutional networks such as schools,

CHEP runs a 5-day Crash Course in Survival Skills for out-of-school youth. On one of the days a policeman advises on how to stay within the law.

churches and youth movements. We therefore decided to approach them directly to learn about their needs and problems. Through focus group discussions with young men, we learned that AIDS was not one of their main concerns. They were curious (rather than concerned) about the effects of alcohol, tobacco and cannabis, but above all they were worried about their economic situation.

Using this information, we designed a five-day Crash Course in Survival Skills tailored to the expressed concerns and particular needs of these youths. The general aims of the course are:

❍ To provide out-of-school youths with practical information on topics that concern them and affect their lives

❍ To encourage them to examine their present life styles and the options available to them

❍ To help them make informed decisions about their economic situation, their health and their sexual behaviour.

Each day in the course deals with a different aspect of survival skills:

Day 1 concentrates on 'staying healthy'.

The subjects covered include AIDS, STDs, and the use of drugs, alcohol and tobacco. Condoms are discussed (and their use demonstrated on a banana), the *Karate Kids* video is shown, and the day finishes with a visit to a local hospital.

On Day 2, participants discuss ways of staying within the law, and a local police officer takes part in a question-and-answer session.

On Day 3, the participants visit an agricultural training centre, where many trainees are third generation city dwellers who are considering working on the land as a career.

Day 4 is devoted to urban-based employment opportunities, in which staff from the Mindola Ecumenical Foundation run sessions in how to run a small business.

On Day 5, the group visits two vocational training centres and receives information about training opportunities. Part of the day is also devoted to a discussion about current social and economic conditions in Zambia. Participants are encouraged not to view themselves as failures, but to develop a strategy for survival in today's harsh social and economic environment. Staying healthy, keeping out of trouble with the law and making a success of their small business are integral components of such a survival strategy.

Since September 1990, we have conducted 18 courses for groups of 10-20 young men*. About two months after each course, a CHEP staff member visits each participant to find out their opinions about the course and to assess its impact on their lives. Each interview lasts 10-15 minutes and covers questions such as the following:

❍ Have you had a sexually transmitted disease since you completed the course? If so, have you been to the clinic for treatment?

❍ How is your business doing? Have you made any changes since you undertook the course?

❍ What are your future plans?

❍ Have you had any trouble with the police?

Most participants report that the sessions on running a business were the most useful. Taking this information into account, the health education sessions now emphasize the importance of staying healthy in order to keep earning money: staying healthy is good for business.

*In early 1992 CHEP began organizing similar courses for young women.

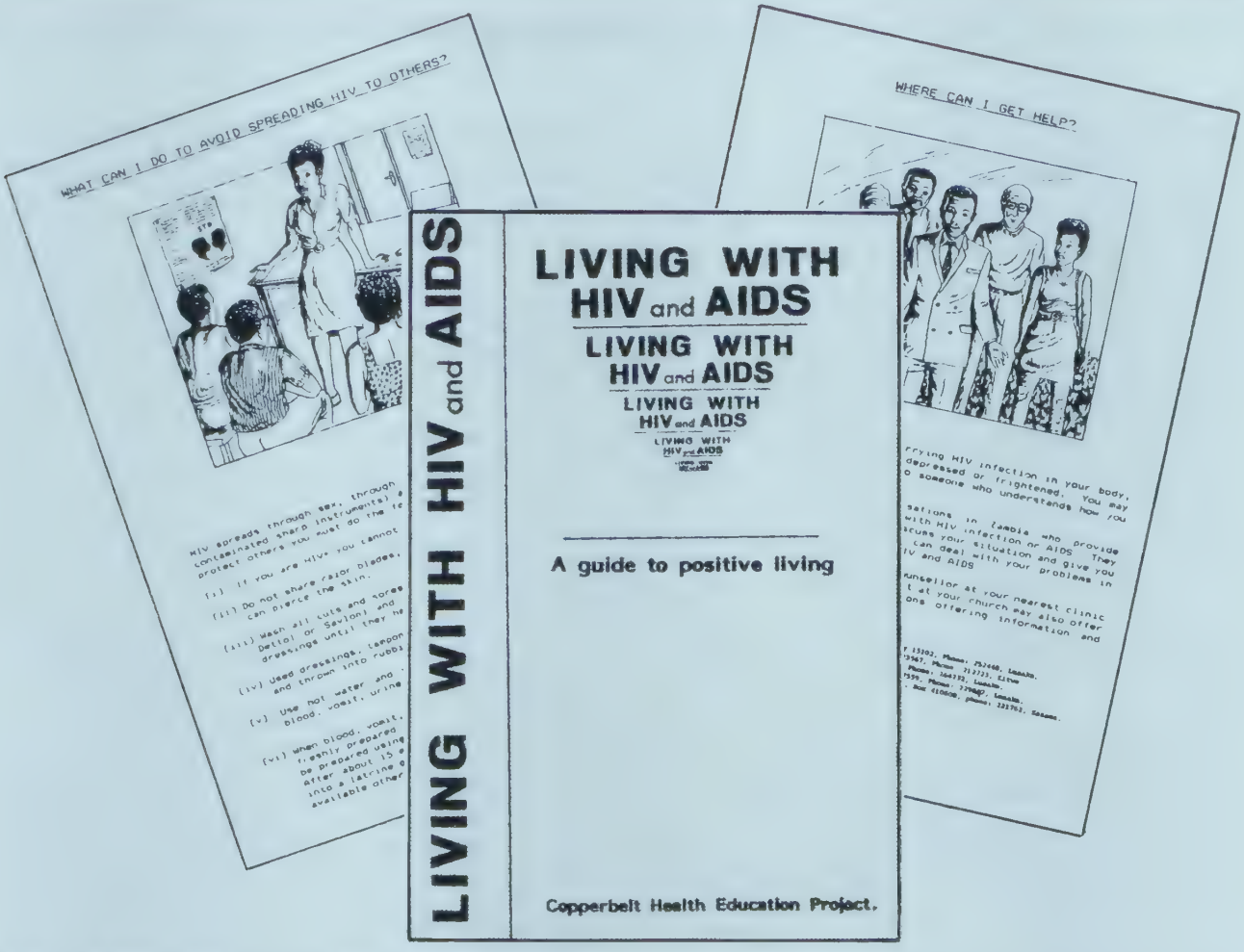
9. People with HIV/AIDS

Another primary target group consists of people infected with HIV, particularly those who have only recently learned that they are HIV-positive. These people are urgently in need of information about the nature of HIV and AIDS, and the implications for their own lives.

In May 1991 we decided to produce a booklet aimed specifically at people already infected with HIV. At first we were reluctant to produce such a booklet – the first of its kind in Zambia. It meant widening the focus of our programme, which previously had concentrated on AIDS prevention. However, several AIDS counsellors in the Copperbelt urged us to do so because their clients needed a booklet in simple, direct language about HIV and AIDS, and how to live with the virus. We were also receiving a growing number of requests for information of this kind through our write-in advisory service. Finally, when a member of the Lusaka-based AIDS support group PALS (Positive and Living Squad) urged us to produce such a booklet, we decided to give it a try.

First, we consulted with colleagues already involved in counselling people with HIV and AIDS – especially the Lusaka Home Care Project and Kara Counselling – on the proposed target audience and contents of the booklet. These discussions were extremely useful. We decided to produce a booklet that would focus on people with HIV infection who either had not yet developed symptoms of the disease or were in the early symptomatic stage. Most of these people would only recently have received the diagnosis of their HIV seropositivity. Their need for information

A health worker counsels an HIV-positive patient.


WHAT CAN I DO TO AVOID SPREADING HIV TO OTHERS?
WHERE CAN I GET HELP?
LIVING WITH HIV and AIDS
LIVING WITH HIV and AIDS
LIVING WITH HIV and AIDS
LIVING WITH HIV and AIDS
LIVING WITH HIV and AIDS
A guide to positive living
Copperbelt Health Education Project.

***Living With HIV and AIDS*, a 20-page booklet written particularly for people with HIV infection.**

would, at least for the time being, be greater than their need for emotional comfort and spiritual support.

We began by consulting with AIDS counsellors in Kitwe and Ndola on the topics that should be covered by the booklet, and also culled information from publications produced for similar purposes in Zimbabwe, Uganda and the U.K. We then prepared a draft text, which was reviewed by officials from the National AIDS Prevention and Control Programme and people from NGOs directly involved in AIDS counselling, including an HIV-positive person. After the text had been finalised, our artist developed sketches, which were pre-tested and revised wherever necessary.

The basic message of the booklet is also summed up in the slogan: "From today, do not think about dying of AIDS. Instead, think about living with HIV!"

The booklet, entitled *Living With HIV and AIDS: a guide to positive living*, was published in September 1991. The highlight of the ceremony to mark its publication was a speech by Simon Mulenga from PALS, who said that the booklet would be invaluable to people like himself who were "groping in the darkness of fear, doubt and lack of knowledge".

Because of the collaborative way in which the booklet was developed, it is not viewed as CHEP 'property', but as the product of a joint effort involving government, NGOs and the people for whom it is intended. An initial 10,000 copies have been printed and distributed to hospitals, other health institutions and NGOs throughout Zambia.

10. 'Gatekeepers'

Much of our work consists of informing, training, motivating and supporting groups of care-givers and opinion leaders who, because of their professional or personal status, can act as 'gatekeepers' to large sections of the general public. As well as communicating information about AIDS, many members of these groups are also well placed to provide the social, psychological or spiritual support needed to motivate people to practise safer sexual behaviour. We have categorized these groups as follows:

- Health workers
- Traditional healers
- Religious leaders
- Teachers and educators
- Journalists
- Formal sector workforce
- Political leaders.

Health workers

Health workers were not a high priority target group for CHEP during the first two years of our activities, when our main focus was on providing information about AIDS directly to the general public. We organized a few seminars for doctors, nurses and clinical officers, but these were on an occasional basis only.

Towards the end of 1989 we realized that this approach was flawed. By giving low priority to health workers we were failing to support them in their efforts on the front-line of the struggle against AIDS. As health professionals, their advice on health issues is often sought out and respected. In a recent survey in the Copperbelt and Northern Provinces, for example, 48% of people interviewed said they would go first to a health worker for information about AIDS; other sources of information were cited in very small numbers[8].

AIDS, however, is a new disease, fraught with uncertainties, sensitivities and controversies. Having completed their professional training before AIDS became a major health problem, many health workers have never received any formal training in AIDS control and prevention. They are, however, aware of the need to improve their knowledge and practical skills in the diagnosis and management of AIDS, and in coping with its social and psychological consequences.

In mid-1990 we began to conduct training workshops on AIDS prevention and control for health workers in all eight Districts of the Copperbelt Province[9]. These workshops have the following specific objectives:

- to provide health workers with factual knowledge about HIV and AIDS

- to introduce health workers to technical skills such as dealing with patients with AIDS-related diseases, handling infectious materials and the sterilization of equipment

- to create a setting suitable for the exploration of feelings about sex,

responsibility towards others, compassion and death

❍ to improve the communication skills of health workers so they can give advice to their patients on sensitive topics

❍ to generate confidence and encourage commitment to put into practice what has been learned in the training workshop.

We have since conducted at least one workshop in each of the eight Districts of the Copperbelt Province, with 20-25 participants each time.

The workshops concentrate in particular on the diagnosis and clinical management of HIV/AIDS; infection control procedures in hospitals and health centres; the use of condoms in the control and prevention of HIV infection; ethical issues in AIDS control and prevention (e.g. 'informed consent' before HIV testing, and informing the spouse of a positive HIV test); TB control and prevention;

Condoms

Health workers often have to treat people whose sexual behaviour places them at a high risk of becoming infected with sexually transmitted diseases. For such people, the regular use of condoms with all their sexual partners could provide a high degree of protection against HIV infection and AIDS. Yet it cannot be assumed that all health workers are well informed about condoms and convinced of their usefulness in the control and prevention of AIDS. Indeed, the opposite is often the case.

In September 1990 we asked 52 qualified and experienced health workers from Kitwe and Ndola about their knowledge, attitudes and practices in relation to condoms. Some of their responses were as follows:

● When asked "Do you promote condom use among your patients who practise high-risk sexual behaviour?", 48% answered "Yes, always", 46% answered "Yes, sometimes", and 6% answered "No".

● Responses to the question "How are condoms to be used?" revealed significant knowledge gaps in 29% of cases. Very few people were aware, for example, of the need to pinch the tip of the condom to expel the air before rolling it on to the man's erect penis.

● When asked "Under ideal conditions, how effective are condoms in preventing STDs and AIDS?", 29% answered "very effective", 67% answered "somewhat effective", and 4% answered "not effective".

We passed the findings of this study on to the Ministry of Health, who in turn produced a leaflet entitled *What medical and health staff should know about condoms*, which we have distributed to health workers throughout the Copperbelt. We also use it in our AIDS workshops.

More and more health workers now promote the use of condoms by people who are either unwilling or unable to avoid having multiple sexual partners. Some health workers, however, still feel that to promote the use of condoms is equivalent to encouraging or at least condoning promiscuity. As one nurse explained:

"I know the whole family— the husband, the wife and the four children. They all come to the clinic when they are ill. How can I help the husband to be unfaithful to his wife by encouraging him to use condoms, and by actually giving him condoms?"

control and prevention of sexually transmitted diseases (STDs); rational blood use in hospitals; how to communicate with patients and family members about sensitive topics.

Every workshop includes several question-and-answer and discussion sessions. On several occasions participants have asked the question: "If people with AIDS are going to die anyway, why should we spend precious money and waste precious drugs on them?" It is very important to respond effectively to this question. If health workers are not convinced that it is worthwhile spending time, effort and money to treat people with AIDS, they will not willingly do so, and the quality of the care they give will suffer. Our response is along the following lines:

❍ Prompt treatment of opportunistic infections can not only prolong life but also improve the quality of a person's life.

❍ Appropriate treatment can reduce the economic impact of AIDS on the family

Rational blood use

"Have you grouped and cross-matched blood for the case?"

Until recently, this was a standard question asked by surgeons and anaesthetists at Kitwe Central Hospital. Since the emergence of the HIV/AIDS epidemic, however, doctors at the hospital have had to review their blood transfusion practices.

With levels of HIV infection among blood donors ranging between 13% (in rural areas) and 23% (in urban areas), the use of unscreened blood for transfusions is out of the question. As in other hospitals in Zambia, all blood used for transfusions at Kitwe Central Hospital is routinely screened for HIV antibodies. But this places extra demands on staff time and also requires a regular supply of HIV test kits and reagents, which in turn have to be paid for. In any case there is always the possibility – however small – of HIV-infected blood not being identified by the test. In addition, diseases such as Hepatitis B and malaria can also be transmitted through infected blood.

During 1990 Dr Narayan Rao, Head of the Department of Surgery at Kitwe Central Hospital and also Chairman of CHEP, decided to make a serious effort to reduce the number of blood transfusions carried out at the hospital and also the amount of blood used. Deciding that personal example would be the best means of persuading his colleagues to change their practice, he began avoiding transfusions unless absolutely necessary. Over a six month period he carried out 56 major operations and transfused blood in only seven cases. Two patients who were not transfused died subsequently, but in neither case were these deaths due to the lack of a blood transfusion.

Once Dr Rao's colleagues were convinced that the use of blood in surgery could be reduced significantly without increasing post-surgical complications or death rates, they began to follow his lead. A new set of guidelines for the appropriate use of blood was drawn up for use by all operating surgeons. Between 1989 and 1990 the amount of blood used for transfusions at Kitwe Central Hospital fell from 3,910 to 2,202 units. These days a hospital patient is given blood only if he or she requires it in a life-threatening situation. Gone are the days when a doctor would say: "The patient is a little bit anaemic. Let's give her a pint of blood before she goes home, just to be safe."

by maintaining the productivity and income-earning capacity of the person for as long as possible.

❍ Early diagnosis and treatment of TB in a person with HIV/AIDS can reduce the spread of TB germs to other HIV-infected people and within the wider community.

❍ Prompt treatment of sexually transmitted diseases can reduce the transmission of HIV itself.

At first I did most of the teaching at these workshops. My colleague, Mr Shaddy Chondoka, who is an experienced clinical officer, soon began to share the workload. By the end of 1990, however, most of the teaching was being done by an Outreach Team of local doctors, clinical officers, nurse tutors and other health professionals from other health institutions (mainly government hospitals), who work for CHEP on a part-time basis.

Counselling

Before 1989 there were very few trained AIDS counsellors in Zambia and none at all in the Copperbelt. Yet there was an overwhelming need for skilled psycho-social support for the rapidly growing numbers of people with HIV/AIDS and their families. The unenviable task of breaking the news of a positive HIV test was the responsibility of doctors, sometimes with support from pastoral workers. Apart from being untrained for this highly sensitive task, doctors also rarely had the time to do it properly. As a result, many patients were never told that they were infected with HIV, and were discharged from hospital without knowing that they could pass the virus on to their sexual partners. Other patients were simply informed that they were HIV-positive but were not offered any counselling to help them cope with the potentially devastating psycho-social impact of this information.

This was obviously an intolerable situation, and in early 1989 the National AIDS Prevention and Control Programme took decisive action to remedy it. A three-phase training course in AIDS counselling for health and social workers from all over the country was held in Lusaka. This was followed by a similar course for 20 health workers in Ndola, capital of the Copperbelt Province, which one of our staff, Mr Shaddy Chondoka, attended.

In response to the urgent need for trained AIDS counsellors, we decided to expand the scope of our activities to include this new field. In 1990 we organized two AIDS counselling workshops for 50 health workers from governmental and non-governmental health facilities in the Copperbelt. We also helped the Ministry of Health train 35 health workers from the various Divisions of Zambia Consolidated Copper Mines.

We tried to obtain trainees from every hospital department likely to come into contact with people with HIV or AIDS, namely, the medical and surgical departments, the paediatric ward, the laboratory and the blood bank. We made a particular point of inviting the 'in-charge' nurses from these wards, or at least involving them in the process of selecting the right staff member for training.

Before accepting a person for training, we explained the 'pros and cons' of working as an AIDS counsellor. We pointed out that, although the course would give them new knowledge and skills, the work itself would be exhausting and emotionally taxing, and was unlikely to result in any increase in salary. Despite these warnings, there was no shortage of volunteers for the courses.

Initially, however, many of the newly trained AIDS counsellors encountered a great deal of resistance from their colleagues. Doctors protested that the

A workshop for health workers. As AIDS is a relatively new disease, with far-reaching social consequences, it is essential to equip health workers with clinical knowledge as well as good communication skills.

counsellors were 'interfering' with their patients. Hospital matrons complained that valuable staff time was being wasted by 'chatting' with patients, and administrators were worried that counsellors would start demanding over-time payments. We informed senior officials in the National AIDS Prevention and Control Programme about these developments, and also encouraged counsellors to form local committees to provide mutual support. We also suggested that counsellors should use clinical meetings to impress upon their colleagues the importance of counselling in the management of HIV and AIDS.

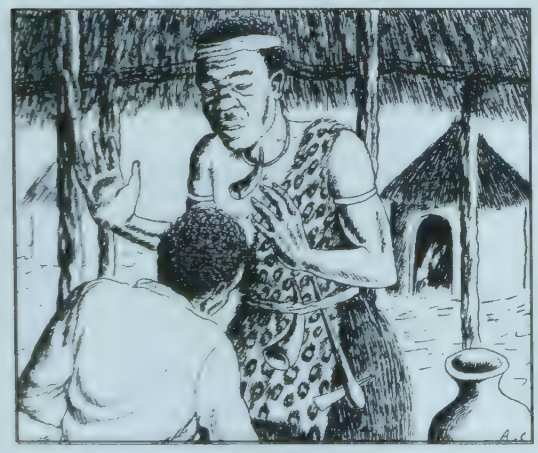
These steps seem to have paid dividends. More and more counsellors have been reporting that they now have the support and confidence of their colleagues and superiors.

As a result of all these efforts, most people with HIV or AIDS in most hospitals in the Copperbelt now receive at least basic counselling before and after an HIV test. Working conditions, however, are far from ideal. Often the counsellor has to stand by the patient's bedside in the middle of a busy ward. Most such sessions last only about 20 minutes or even less, due to the small number of trained counsellors and the large numbers of patients. In these situations an over-worked counsellor could easily miss important points. We have therefore produced and distributed a check-list as a memory aid for newly trained counsellors.

During the course of the 1990s the numbers of people in Zambia diagnosed HIV-positive, or as having AIDS, are

likely to increase dramatically. This will result in a massive increase in the need for AIDS counselling services. In order to cope with this need, all health workers must be trained to provide at least basic counselling support to people with AIDS and their families. A smaller number of health professionals should also receive further training in order to provide technical back-up and supervision. CHEP is committed to helping to meet this challenge.

Traditional healers



The traditional healer is an integral part of African culture. Even in a country such as Zambia, where half the population lives in urban areas, most people have tremendous faith in traditional healers and seek their help for many health problems. Many Zambians believe that there are two distinct types of diseases – those that can be treated by modern medicine, and those that can be treated only by traditional African medicine. AIDS is widely regarded as the second type of disease. Given the unpredictable nature of the disease, and the fact that modern doctors readily admit that they have no cure for its underlying cause, it is hardly surprising that many people turn to traditional healers in their search for a cure.

Some practices of traditional healers may contribute to the spread of HIV through contaminated blood. The use of unsterilized cutting instruments such as razor blades to carry out ritual scarification, or to make cuts in the skin for the insertion of medicinal herbs, may account for a small proportion of HIV infections in Zambia.

But traditional healers are also a potentially powerful force in the national effort to control and prevent AIDS, and to provide care and support for those affected by the disease. Their herbal remedies can help to treat infections associated with AIDS, and to provide relief from troublesome and persistent symptoms. They can also provide invaluable psychological and emotional support to people with AIDS and their families. As a trusted source of information about health and disease, they can also help to promote safer sexual behaviour and thus reduce the spread of HIV.

We decided to try to enlist the support of traditional healers in our work from the very start. We began, however, by carrying out a small study to find out what they already knew and believed about AIDS. We interviewed 50 traditional healers in Kitwe and found that, although all had heard of AIDS, there were also important gaps and misunderstandings in their knowledge. Many believed, for example, that AIDS was simply another name for a disease called *ukondoloka*, which a man could contract by having sex with a widow, a woman during her menstrual period, or a woman who has had a miscarriage. More than 80% also believed that AIDS could be cured by 'African medicine'.

We then contacted TAPAZ (Traditional Practitioners Association of Zambia), and offered to fund and help organize regular 'consultations' to share information about AIDS and other sexually transmitted diseases between traditional and modern health practitioners. We also contacted the provincial and district level Cultural Officers, these being the Government officials responsible for coordinating the work of traditional healers.

The 'consultations', which are attended by 25 to 50 participants, have become an annual event in each of the eight Districts of Copperbelt Province. Each meeting brings together traditional healers and modern health workers (doctors, nurses and clinical officers) to exchange information and views about HIV and AIDS. More recently, staff from the Department of Forestry and Wildlife have also attended and spoken on the topic of medicinal herbs.

The going is not always smooth, and the discussions sometimes develop into arguments. On more than one occasion traditional healers have rejected scientific explanations of HIV and AIDS. "Why," they demand, "should we believe what you say when you do not believe what we are saying?" On the whole, however, the atmosphere has been relaxed, friendly and mutually respectful. Through these consultations about 750 traditional healers have become more aware of HIV and AIDS and now are involved, to varying degrees, in the national effort to control and prevent AIDS, and to provide care and support to those affected.

Many traditional healers are now prepared to inform their clients that there is no cure for AIDS, although their treatments can provide relief for certain symptoms. Many now use bleach to disinfect the razor blade used for scarification or other skin-piercing procedures. Many also encourage their clients to adopt safer sexual behaviour.

Sometimes, however, simply providing information about AIDS is not enough. In 1989 a traditional healer produced a leaflet entitled *The Facts about AIDS*, which made some outrageous claims – for example, that AIDS is contracted by persistent coughing, through smallpox, through having sex with a woman during menstruation, or simply by playing with a baby whose parents have AIDS. A health worker from Kitwe Central Hospital brought the leaflet to us, and we invited the traditional healer to our office for a frank discussion of its contents. We also informed the District branch of TAPAZ, who ordered the person concerned to stop distributing the leaflet immediately. He complied with this order, and there have been no hard feelings since. In fact he now proudly displays a CHEP calendar in his 'surgery'.

Religious leaders

AIDS affects a person's life in every way – physically, emotionally, economically, socially and spiritually. Religious leaders and members of their 'faith communities' can provide a tremendous amount of support to people with AIDS and their families, and can also help to influence people's sexual attitudes and behaviour. They are therefore valuable allies in the fight against AIDS.

CHEP's work with religious leaders is in support of activities initiated by the Ndola Catholic Diocese, which also involve other churches. We aim to provide religious leaders with accurate information about AIDS and to motivate them to become involved in the national effort to combat the disease and provide care and support to the people most severely affected. We therefore participate regularly in AIDS seminars for religious leaders throughout the Province, providing technical information and learning materials.

During 1990-91 at least five three-day

AIDS seminars for religious leaders have been held in each of the eight towns in the Copperbelt, with 25-50 people participating in each. The participants were deeply concerned about the sharp increase in funerals of young adults in recent years. Significantly, the religious leaders themselves were often unaware that there was a medical problem in the family until asked to conduct the funeral service. People who normally spoke about their problems with their spiritual leaders were making every possible effort to conceal the problem of AIDS and even to deny its existence. There seemed to be a 'conspiracy of silence' about AIDS, probably because it is seen as a 'shame disease' due to its association with sex outside marriage. The religious leaders were also disappointed that some medical personnel seemed to be part of this 'conspiracy' because of their unwillingness to inform people diagnosed HIV-positive.

But the religious leaders were also self-critical. If people with AIDS and their close relatives did not expect effective help from their religious leaders, this was surely a challenge to the professional competence of these leaders and to the attitudes of the members of their churches. It was clearly important for the churches to make a major effort to 'de-stigmatize' AIDS so that the question of how to cope with it could be addressed in a spirit of openness and honesty. They also agreed that effective action against AIDS calls for all churches to work more closely

Religious leaders are well placed to provide practical and emotional support to people with AIDS and their families.

Health Library and Information
Bangalore

together, in collaboration with health workers, teachers and educators.

It is clear that the seminars have helped to increase awareness and knowledge of AIDS among religious leaders in the Copperbelt. Many are now alert to AIDS symptoms and, where possible, help the person to obtain appropriate medical care. In at least three towns on the Copperbelt – Ndola, Kitwe and Chingola – members of 'small Christian communities' have begun visiting people with AIDS in their homes to offer care, comfort and practical support. Some pastors have been trained as counsellors and now approach sick people and their families with greater sensitivity and professional skill. On the other hand, there are still a number of religious leaders who believe that AIDS is basically a punishment from God.

The condom issue remains a sensitive matter. There is general agreement that it is not the task of the churches to promote the use of the condom to limit the spread of HIV infection. Yet many pastors openly admit that the churches' policy of chastity before marriage and faithfulness within it is widely disregarded. Some religious leaders are now trying to bring about an informed, responsible discussion on sexuality, including the use of condoms, thus enabling individuals to make appropriate, responsible decisions.

Some religious leaders are questioning whether they are doing enough by simply 'visiting the sick'. They are acutely aware of the many and varied needs of both the sick person and the family. They are also aware of the ever-growing need for them to be 'bridge-builders', bringing together parents, teachers and medical personnel, and also to foster more community initiatives in support of people with AIDS and their families. Many feel the need to develop the communication and management skills required to cope with these challenges. CHEP remains committed to supporting them through information and training.

Teachers and educators

The education system is a potentially important channel for disseminating health knowledge and influencing the attitudes and behaviour of young people. There are many more school teachers than health workers and they are in regular contact, over several years, with school children and their parents. Teachers are also influential members of their communities.

Education about AIDS and other sexually transmitted diseases is not yet part of the syllabus of Zambia's schools, nor does it appear on the curriculum of teacher training colleges. Yet most Zambian children become sexually active at a relatively young age and are therefore at risk of becoming infected with HIV. In a recent survey of 200 pupils (aged 16-22 years) from eight secondary schools in the Copperbelt, we found that 48% of girls and 73% of boys claimed to have had sexual intercourse. The average age at which they first experienced intercourse was 16 for girls and 15 for boys[10].

Paradoxically, many Zambian school pupils are better informed than some of their teachers about AIDS. This is largely due to the work of the Anti AIDS Project, a non-governmental organization started in 1987, which has produced a wide range of booklets, magazines, posters, leaflets, calendars, T-shirts and other materials carrying information and specific messages aimed at young people. The Project has also encouraged the formation

of Anti AIDS Clubs aiming to help young people avoid HIV infection, educate their friends and relatives, and provide care and support to people with AIDS in the community. Over 700 such clubs have been formed, including about 350 in primary and secondary schools.

In 1988 and 1989 CHEP conducted AIDS seminars for primary and secondary school teachers, and District Education Officers. We had two basic objectives: first, to increase teachers' knowledge and awareness of AIDS as a social and health issue; and second, to encourage teachers to become involved in AIDS education in schools as well as in the wider community. The seminars, however, were organized on a fairly ad hoc basis and were not part of a broader plan or strategy.

By late 1989 we realized that a more systematic approach was needed. Many school pupils, including many who were already sexually active, were faced with a multitude of doubts and questions about HIV and AIDS which they felt unable to discuss with their parents, and which very few school teachers were able to help them clarify or answer. Indeed, some teachers were so poorly informed that they even denied the existence of AIDS as a disease.

At this point the Catholic Diocese of Ndola decided to take up the challenge of AIDS education in all eight Districts of the Copperbelt, concentrating on teachers and religious leaders. We joined forces with Sr John Vincent and Fr Frank Carey and their team, and have worked together closely ever since. The Diocesan team began by producing two booklets – *Teachers' Guide to AIDS Control* and *Teachers' Guide to Human Reproduction* – and a set of flipcharts (in English and Bemba) entitled *The Basic Facts about AIDS*. These were based on similar materials produced by UNICEF for schools in Uganda.

In May-June 1990 the Diocesan team, with the support of government Education Officers, organized a series of one-day AIDS seminars for Grade 7 teachers, as well as teachers of Science and Religion, in all eight Districts of the Copperbelt Province. CHEP provided financial support and we also helped to run seminar sessions. Each seminar started with a presentation of the basic facts about AIDS, followed by small group discussions which explored moral and religious issues related to sex education and the disease AIDS itself.

The seminars were very lively and well attended – about 50 participants on average. For many teachers these meetings were the first opportunity they had ever had to clarify their own knowledge of AIDS and to sort out the facts from the many misconceptions that surround the disease. However, the seminars also revealed deep-seated fears, beliefs and attitudes which may obstruct efforts to deal with the issue of AIDS with the necessary openness and honesty.

The topic of sex education often led to heated debates. Many teachers argued that, according to traditional Zambian culture, it is taboo for sexual matters to be discussed outside the extended family. Others pointed out that, especially within the urban setting of the Copperbelt, traditional family structures for sexual initiation and instruction have largely broken down in present-day Zambia. Moreover, many secondary school children are already sexually active and in need of information and guidance, but feel unable to discuss sexual matters with their parents. For their part, parents are often too embarrassed to discuss sexual matters with their children.

Some teachers also objected to what they regarded as the over-explicit language relating to sexuality in the booklet *Teacher's Guide to Human Reproduction*. Others, while declaring themselves willing to use the materials, nevertheless expressed anxiety about the possible reactions of parents.

The condom was another controversial topic. Many teachers felt that health educators were promoting promiscuity and pre-marital sex by promoting the use of condoms. Some also felt that certain teachers might use sex education as an opportunity to mislead and sexually exploit children. The AIDS seminars for teachers have continued in 1991. To promote active learning and a lively atmosphere, we use a variety of activities including games*, group exercises, case studies, role plays, brain-storming sessions and small group discussions. These activities have been very successful in maintaining the enthusiasm of teachers for the workshops. They have also served to train teachers in the use of participatory education techniques, and thus to improve teachers' communication skills.

In mid-1991 we carried out a small study to estimate the coverage and possible impact of the AIDS seminars for teachers in the Copperbelt. In a sample of 50 secondary and basic schools, we found that 29 schools (58%) had been represented by at least one teacher at an AIDS seminar. Schools where a teacher had attended an AIDS seminar were much more likely to have organized a special staffroom session to discuss AIDS, and to be involved in AIDS education within the local community.

Two years ago we felt we were barely scratching the surface with this target group. We have covered a great deal of ground since then, but a tremendous amount of work still remains to be done.

*Two useful resource packs for youth training are:

Action for Youth, produced by the League of Red Cross and Red Crescent Societies;

Unmasking AIDS, produced by the International Planned Parenthood Federation.

Journalists

Journalists have a tremendous responsibility when reporting on HIV and AIDS. Well informed, objective and responsible reporting can help to foster a climate of public opinion in which AIDS is addressed in a spirit of openness and honesty. Journalists can help to provide their readers, listeners and viewers with the basic information needed to make informed decisions about sexual behaviour. They can also help to combat judgemental attitudes and prejudice towards people suspected of having HIV infection or AIDS.

On the other hand, journalists also have it in their power to do a great deal of harm. Through inaccurate, sensationalist or misleading reporting of AIDS-related issues, they can foster fear, prejudice and panic among the general public. They can also sow doubt and confusion, raise false hopes and even destroy people's lives.

Journalists themselves need clear, accurate, relevant and up-to-date information about AIDS. Such information, however, is not always easy to obtain. Some doctors and other health professionals are evasive, secretive or openly hostile towards journalists where AIDS is concerned; others find it difficult to give information without using highly technical medical terminology.

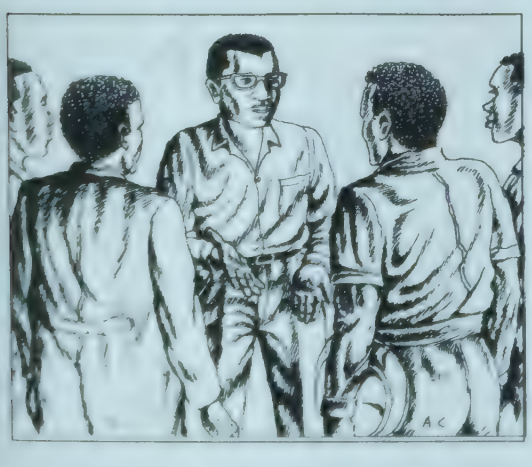
We have made a major effort to provide Zambian journalists with information about AIDS. Journalists in Zambia tend

to cover several subjects rather than specializing in, for example, health-related issues. We have therefore developed contacts with about 50 journalists working for radio, television, newspapers and magazines in the Copperbelt and in the national capital, Lusaka.

There are several ways in which we provide journalists with information: one-day workshops and seminars, organized two or three times a year for groups of 15-35 persons; occasional talks on particular topics (e.g. breastfeeding and AIDS) at the Press Club; invitations to attend public interest events such as the launch of a new AIDS booklet, a poster competition or World AIDS Day; regular mailings of specialist magazines such as *AIDS Action* and *WorldAIDS;* and responses to spontaneous queries from journalists.

As a result of these efforts, journalists in the Copperbelt are fairly well informed about HIV and AIDS. There is a feeling of mutual respect and good-will because we have built up an ongoing relationship with them. They know that we do not regard them as simply an easy way of getting free publicity for our own organization, but as equal partners.

Formal sector workforce



A high proportion of the workforce of Zambia's Copperbelt is employed within the 'formal' sector. The main employer, Zambia Consolidated Copper Mines (ZCCM), has over 50,000 employees. Given that copper alone accounts for 80% or more of Zambia's export earnings, the health of these workers is vitally important to the Zambian economy as a whole.

There are also many other companies employing tens of thousands of people in the Copperbelt – multinationals such as Coca Cola, Johnson & Johnson and Brooke Bond, insurance companies and banks, textile factories and ceramic manufacturers, construction companies and retail firms, and suppliers of equipment, machinery and building materials for industry.

AIDS is now a real threat to the productivity of all industrial and commercial firms in the Copperbelt. If managers, engineers, technicians and skilled workers are frequently absent from their jobs because of AIDS-related illnesses, economic output is bound to be affected. It is also extremely difficult to find qualified staff to replace skilled people when they die or take early retirement due to illness.

Workers within the formal sector also play a key role within the extended family network. Most salary or wage earners in the Copperbelt support several relatives as well as the members of their own immediate family. The loss of their earnings through illness or death therefore has a direct impact on the lives of many members of the extended family. In addition, many men and women working in the formal sector, having 'made good' in the city, are seen by their relatives and friends as role models and have an important influence on the values, attitudes and behaviour codes of their communities.

In deciding to make the formal sector workforce one of our target groups, we had three main objectives in mind:

- to increase their knowledge and concern about AIDS
- to promote safer sexual behaviour

Skilled workers in the Copperbelt are important both to the economy of the country and also as income-earners to their extended families.

❍ to encourage respect and compassion for people with HIV/AIDS in the workplace.

We have used three main channels to reach the formal sector workforce in the Copperbelt: employers, trade union leaders and the mass media.

Employers

We have worked closely with various employers to organize a series of half-day 'AIDS and the Workplace' workshops for middle management staff, shop floor leaders and workers. Between September 1990 and December 1991 we organized 85 such workshops – 10 for the Zambia Consolidated Copper Mines and 75 for other (private and para-statal) companies, in which a total of about 2,500 employees participated.

We have found that relatively homogeneous groups of 30-40 people are most effective for participation and learning. If management and shop floor workers are in the same group, each tends to inhibit the other. Participants are more relaxed, open and active if separate workshops are organized for management and shop floor workers.

By late 1991 we had been able to organize only a few workshops at senior management level. It seems as though many company managers and executives still take the view: "We know all we need to about AIDS, but you can talk to the workers. They need to know..." It is probably true that top level managers do have greater access to information about AIDS than staff on the lower echelons. But if their commitment to the fight against AIDS is not clearly demonstrated, it will be difficult to promote new attitudes and changes in behaviour within the workforce as a whole. It is also important for senior management to consider the implications of high levels of HIV infection in the general public for their own firms –

especially in the fields of social security, training, recruitment and investments in plant and technology.

Our fieldwork team is continuing to create a demand for more AIDS workshops by taking samples of our posters and leaflets to companies in the Copperbelt. By the end of 1991 we had visited about 250 companies in all eight districts of the Copperbelt and distributed our leaflets and posters in each place.

Trade unions

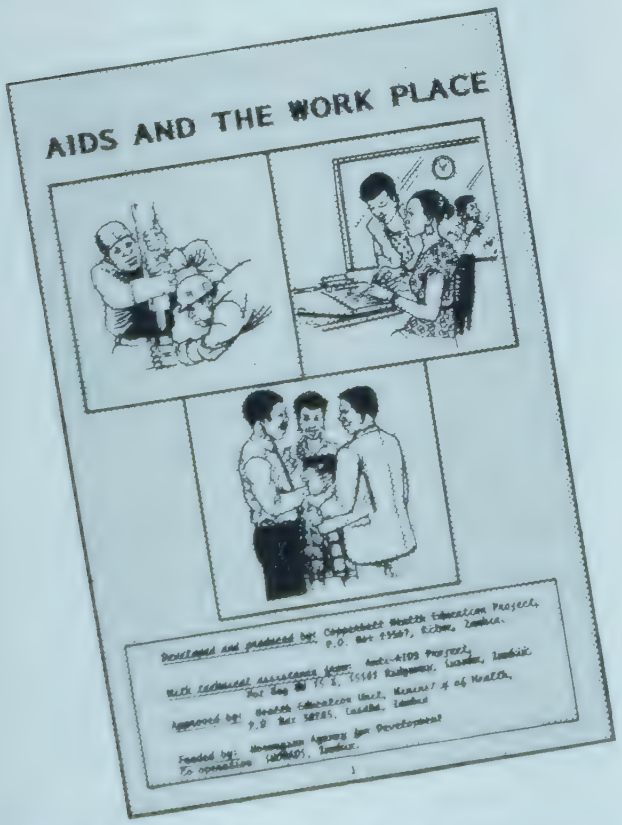
Trade union leaders in Zambia are constantly in the news, fighting for better wages, allowances and working conditions for their members. Many are also deeply involved in politics. They are also concerned about their members' health, and are increasingly aware of the wide-ranging implications of the problem of AIDS.

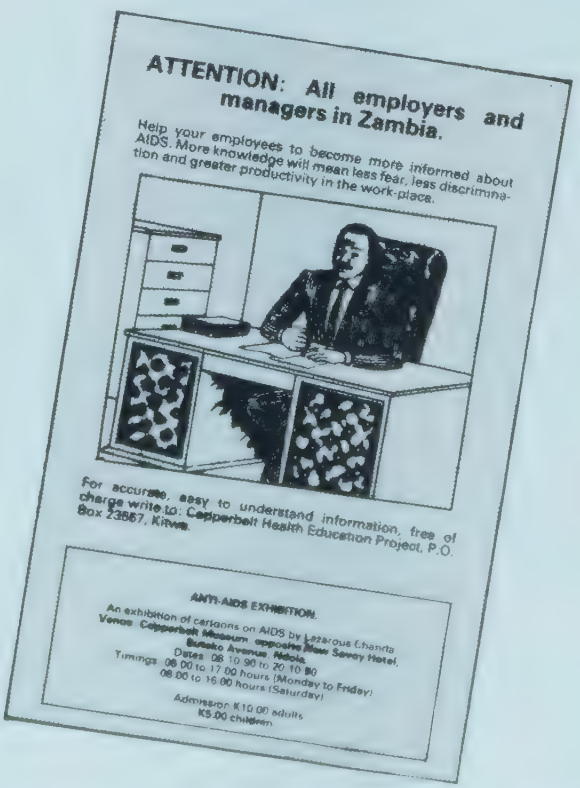
In August 1991 we made a presentation on 'AIDS and the Workplace' at an AIDS seminar organized by the Zambia Congress of Trade Unions in Kitwe. This was a very lively meeting with a high level of participation from the 35 trade union leaders who attended. We are confident that this meeting will be the start of a process of AIDS education and awareness within the trade union movement in the Copperbelt.

Mass media

The formal sector workforce, with above average literacy levels and greater access to the print and electronic media, can be reached quite effectively through the mass media. We used Zambia's leading daily newspaper, *The Times of Zambia*, to serialize our eight-page leaflet *AIDS and the Workplace* on a weekly basis in April-May 1991. *Worker's Voice*, a quarterly paper read widely by trade unionists in the Copperbelt, also serialized the leaflet for its readers.

Our 13-part television series, 'Talking AIDS', which was broadcast in early 1991, was aimed mainly at middle to high




ATTENTION: All employers and managers in Zambia.
Help your employees to become more informed about AIDS. More knowledge will mean less fear, less discrimination and greater productivity in the work-place.
For accurate, easy to understand information, free of charge write to: Copperbelt Health Education Project, P.O. Box 23567, Kitwe.
ANTI-AIDS EXHIBITION
An exhibition of cartoons on AIDS by Lazarous Chanda
Venue: Copperbelt Museum opposite Mine Survey Hotel, Buteko Avenue, Ndola.
Dates: 08.10.90 to 20.10.90
Timings: 08.00 to 17.00 hours (Monday to Friday)
08.00 to 16.00 hours (Saturday)
Admission: K10.00 adults
K5.00 children

Materials designed for the workforce: a leaflet and a newspaper advert for an anti-AIDS exhibition.

income-earners in the formal sector workforce. In an evaluation at the end of the series we found that 77% of a representative sample of this target group in Kitwe District had watched at least one episode, and a third of these had watched the whole series. The contents and presentation of the series were highly acceptable: virtually everyone (98%) found it interesting and easy to understand, and 94% found it realistic. The great majority (75%) said they learned something about AIDS from the series.

Political leaders

Because of their official positions and high public profile, political leaders are an important influence on public opinion. Their statements and views on health issues are widely reported by the mass media. Political leaders are also society's law makers. They have a crucial role to play in creating a legal framework to promote safer sexual behaviour and to support rational and compassionate attitudes towards people with HIV and AIDS.

In focussing on political leaders, we have two main objectives:

- To increase their knowledge and concern about AIDS

- To persuade them to place AIDS control and prevention high on their political and personal agendas.

Our strategy has been to sensitize and train local political leaders such as Ward Chairmen and Women's League leaders, who can disseminate information about AIDS through meetings ranging from neighbourhood groups up to District level gatherings.

Our activities began in May 1988, when we were invited to speak about AIDS to over 600 delegates attending a meeting in Kitwe of the United National Independence Party (UNIP), then the only political party in Zambia. The official response was very encouraging. The Hon. Rankin Sikasula, who represented the Copperbelt on UNIP's Central Committee at the time, delivered a powerful speech, urging Party members to carry the fight against AIDS to every section, branch and ward in the province. The response to this challenge at lower levels of the Party structure, however, was only modest.

We have also spoken about AIDS at UNIP meetings of various sizes. In addition, we have delivered booklets, leaflets and posters to the offices of the Governor, the Political Secretary, the Women's League and the Youth League in all eight Districts, as well as to the Provincial political leadership in Ndola. Along with these materials we distributed a letter offering to organize AIDS seminars for any group, at any place or time, in whatever language required. The response, however, has been very poor: only two responses were received and no follow-up activities were organized.

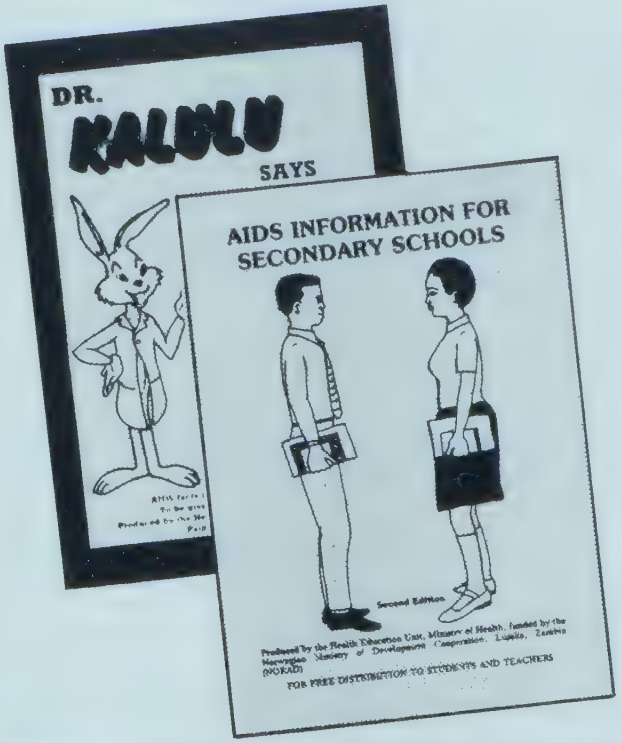
With the smooth and peaceful change of government following the general election on 31 October 1991, there is a new feeling of optimism about Zambia's future. AIDS is only one of many urgent health problems facing the country, but there is every reason to believe that the new government has the political will to give high priority to mobilizing all available resources in the struggle against AIDS.

11. Allies and partners

From the outset, CHEP has tried to work in partnership with other organizations, rather than functioning in isolation and duplicating the efforts of others. As far as the Government is concerned, we have enjoyed an extremely productive partnership with the Health Education Unit of the Ministry of Health at national level. Within the Copperbelt, we have worked within the institutional framework of the Provincial AIDS Surveillance Committee and the local committees in each of the eight Districts of the Province. Our approach is not "We will provide you with materials or funds for such-and-such a purpose." It is, rather "Is there anything we can do to help you in your work?"

We provide District AIDS Surveillance Committees with a wide variety of educational materials, and also with modest amounts of funds, for example, for World AIDS Day activities and other special events. We also make a point of sharing the credit for achievements, for example, by giving prominent acknowledgement to government agencies for their role in developing the booklets and other materials we publish. Government officials, for their part, realize that we are not in competition with them, and accept us as allies rather than viewing us as rivals.

We also work closely with other Zambian and international NGOs. One of our long-standing partners is the Anti AIDS Project, a Lusaka-based voluntary agency which produces excellent materials aimed mainly at children and youth in schools, colleges and universities. To avoid duplication, we produce no materials at all for these groups, but simply distribute the Anti AIDS Project's booklets, posters and materials as widely as possible, especially within the Copperbelt.



Booklets for primary and secondary schools produced by the Lusaka-based Anti AIDS Project.

We also collaborate with the Kara Counselling and Training Trust, most recently in the pre-testing and revision of materials such as the booklet *Living With HIV and AIDS*. Another important partner organization is PALS (Positive And Living Squad), a recently formed group consisting entirely of people with HIV/AIDS. In February 1991 Wingston Zulu, a founder member of PALS, appeared in our televison series 'Talking AIDS' and publicly declared his HIV-positive status – the first time anyone had ever done this in Zambia.

We have also worked with AIDSCOM, the USAID-funded AIDS education initiative implemented by Johns Hopkins University. In 1990, for example, we helped AIDSCOM to carry out focus group discussions with radio listeners in three different parts of the country. Our own staff also benefitted from this cooperation by improving their communication knowledge and practical skills.

12. Personnel

CHEP began, in 1988, with a Project Coordinator and an Office Assistant. Four years later, in January 1992, the Project employed eleven full-time staff, as follows:

- Director
- Project Coordinator
- Assistant Coordinator and Office Manager
- Secretary/Administrator
- Office Assistant
- Fieldworkers/Outreach Educators (2)
- Evaluation officers/Outreach Educators (4).

From the outset, we have emphasized the importance of staff development through on-the-job training and participation in short courses. Only one of our fieldworkers and evaluation officers has been professionally trained. The others are all young secondary school leavers who, in the course of their work, have learned practical skills such as how to carry out focus group discussions, design and administer a survey questionnaire, tabulate and analyse survey results, write a survey report, and pre-test educational materials. Some have also become adept at giving talks about AIDS and organizing training workshops for groups such as out-of-school youth.

We regularly set aside a certain amount of work time for study and discussion. In the second half of 1991, for example, we devoted one afternoon a week to reading together and discussing the book *Partners in Evaluation*[11].

In addition, we have a constantly expanding Outreach Team consisting of doctors, nursing tutors, clinical officers, community health workers, family health nurses, prison officers, police officers, social workers, counsellors, teachers and educators. Working for CHEP on a part-time basis, and receiving only a modest honorarium, members of the Outreach Team conduct training sessions for groups such as health workers, employers, trade union leaders, teachers and traditional healers. It is due mainly to the Outreach Team that CHEP has been able to organize a large number of AIDS seminars and workshops for groups of people from many sections of the population.

In order to meet the constantly increasing demand for AIDS education and training, CHEP's full-time staff will need to be expanded. To respond to local AIDS education and training needs, inter-disciplinary Outreach Teams of part-time CHEP workers will be formed in each of the eight Districts in the Copperbelt. Everyone involved in CHEP – whether full-timers or part-timers – will participate in in-service training according to the needs and interests of each individual. Some staff, for example, are anxious to improve their communication skills, while others want to improve their technical knowledge about HIV and AIDS. Meetings will also be held to exchange experiences and discuss common problems, concerns and emerging issues.

Opposite: A group of CHEP workers discuss their plans for a seminar.

13. Funding

Since its inception in 1988, CHEP's main source of funds has been NORAD (the Norwegian Agency for Development Cooperation). NORAD has been an extremely good partner. The Agency has not tried to impose its own views or personnel upon CHEP, or to make unrealistic administrative demands. It does, however, insist on a few 'ground rules', which can be summarized as follows:

- The project must fit in with the policies of the National AIDS Prevention and Control Programme.

- The project must have clear-cut objectives and strategies, and should have indicators of progress built into the proposal.

- Audited reports must be submitted periodically (in the case of CHEP, every six months).

We have also received financial support from the World Health Organization (via the National AIDS Prevention and Control Programme), Christian Aid (U.K.), and the Southern African AIDS Training Programme (funded by the Canadian International Development Agency).

During the second half of the 1980s it was relatively easy for well-organized NGOs to obtain funds from international donor agencies for AIDS prevention work in developing countries. That is no longer the case. There are now many more NGOs competing for limited resources, and donor agencies have become more selective about the projects they support. There is an urgent need for NGOs and donors to agree on a framework for assessing which strategies and programmes are most effective – and affordable – in promoting the attitudes and behaviours needed to combat the spread of HIV and AIDS.

14. Are we having any impact?

CHEP's work, along with that of other NGOs and the National AIDS Prevention and Control Programme, has helped to mobilize many sections of the community in a joint effort to control and prevent AIDS. We believe that this joint effort has helped to empower many people with the information and support they need to protect themselves and others against the disease. There is also mounting evidence that growing numbers of people in the Copperbelt have changed their sexual behaviour, and that this may be helping to reduce the spread of HIV and AIDS.

Knowledge, attitudes and behaviour

When we started our programme in 1988 none of us in CHEP had any formal training in health education or communication methodology. We began our activities without carrying out any surveys of the population whose knowledge, attitudes and behaviour we were trying to influence. As a result, we do not have any baseline data to make any 'before and after' assessments of the impact of our various activities.

At the end of 1988 and in mid-1989, however, we carried out two Knowledge, Attitudes and Practice (KAP) studies on AIDS within the general population of the Copperbelt. These found that, although well over 90% of the population had heard about AIDS, there were also a number of important knowledge gaps and misconceptions. The 1988 study, for example, found that 18% of respondents thought that HIV could be transmitted by insects, non-sexual body contact, and sharing eating utensils; another 31% were unsure whether or not HIV could be spread in these ways. The 1989 study found that 22% of respondents thought that HIV could be transmitted by mosquitoes, and another 9% were unsure. These studies have helped us to design messages and produce materials aimed at meeting the information needs of the general public.

In 1991 we received evidence that our efforts – and those of our many allies and partners – were having some impact. A study carried out in the Copperbelt and Northern Provinces* by AIDSCOM and the Ministry of Health found a very high level of knowledge of HIV and AIDS within the general population[12]. Asked to give one or more responses to the question "How can a person get AIDS?", and without being given any answers to choose from, respondents replied as follows:

- many sexual partners 51%
- sexual relations 32%
- sleeping around 23%
- other ways 19%
- blood transfusions 16%
- injections 11%
- sex with a prostitute 3%
- working with someone with AIDS 2%
- using the same plate as someone with AIDS 2%
- shaking hands with someone with AIDS 1%
- witchcraft 1%

It was striking how many people cited sexual intercourse as a way of getting AIDS. Equally remarkable was how few people cited non-sexual body contact, sharing eating utensils, or working with a person with AIDS as ways of contracting the disease.

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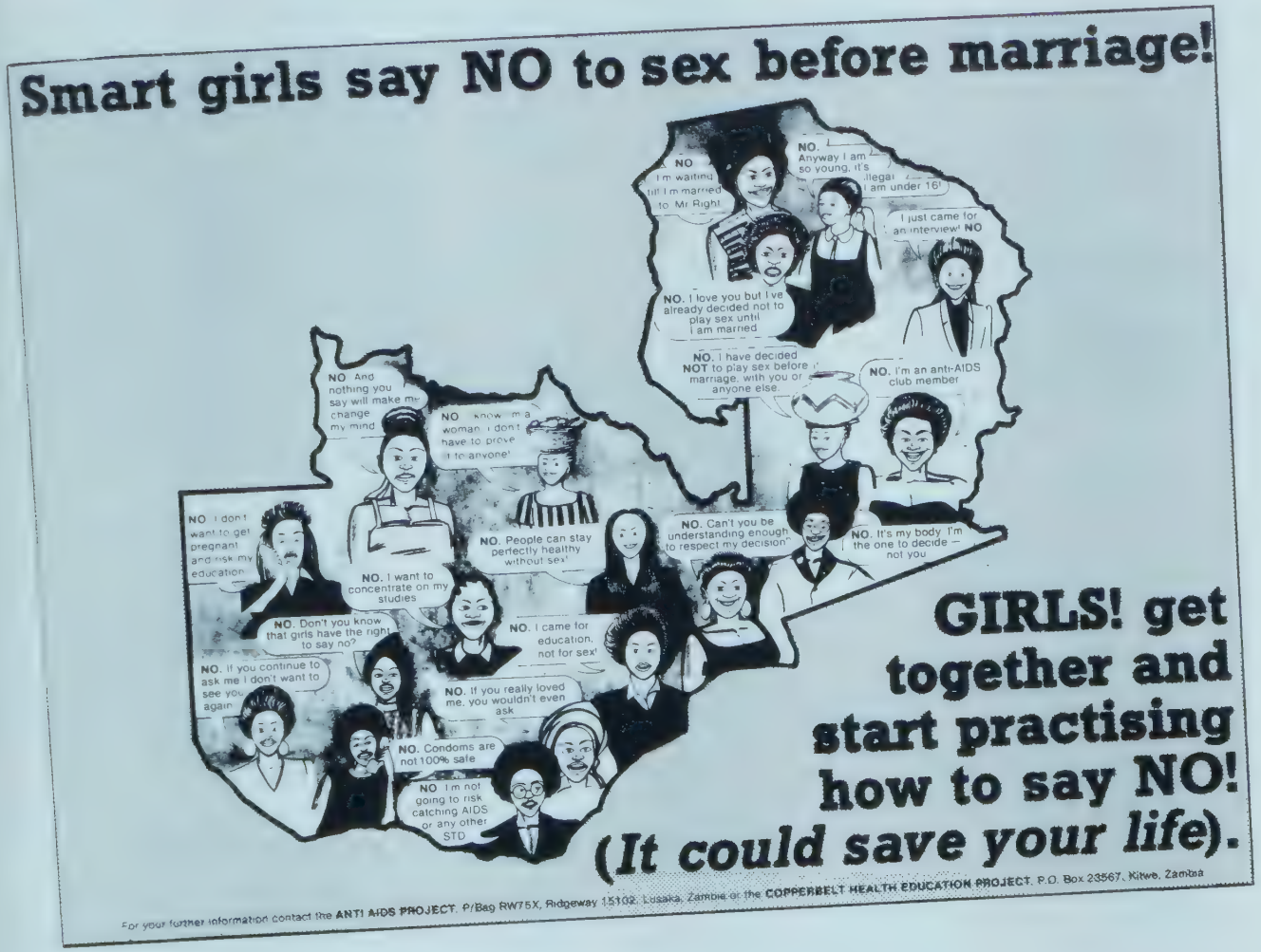
*The study sample consisted of 1,680 men and women aged 15-45 years: 1,250 from the Copperbelt and 430 from Northern Province.


Smart girls say NO to sex before marriage!
NO. I'm waiting till I'm married to Mr Right
NO. Anyway I am so young, it's illegal I am under 16!
I just came for an interview! NO
NO. I love you but I've already decided not to play sex until I am married
NO. I have decided NOT to play sex before marriage, with you or anyone else
NO. I'm an anti-AIDS club member
NO. And nothing you say will make me change my mind
NO. I know I'm a woman, I don't have to prove it to anyone!
NO. I don't want to get pregnant and risk my education
NO. People can stay perfectly healthy without sex!
NO. I want to concentrate on my studies
NO. Can't you be understanding enough to respect my decision?
NO. It's my body I'm the one to decide — not you
NO. Don't you know that girls have the right to say no?
NO. I came for education, not for sex!
NO. If you continue to ask me I don't want to see you again
NO. If you really loved me, you wouldn't even ask
NO. Condoms are not 100% safe
NO. I'm not going to risk catching AIDS or any other STD
GIRLS! get together and start practising how to say NO! (It could save your life).
For your further information contact the ANTI AIDS PROJECT, P/Bag RW75X, Ridgeway 15102, Lusaka, Zambia, or the COPPERBELT HEALTH EDUCATION PROJECT, P.O. Box 23567, Kitwe, Zambia

A poster promoting change in sexual behaviour and attitudes, produced in cooperation with the Anti AIDS Project, Lusaka.

The AIDSCOM study also found that a remarkably high proportion of people – 62% – claimed to have changed their sexual behaviour in order to avoid getting AIDS. More men than women claimed to have changed their behaviour: 75% compared with 50%. Of those who reported changing their behaviour, the majority (63%) said they were staying with only one sexual partner. Another 9% said they no longer went with bar girls. Only 3% said they had started using condoms to avoid getting AIDS.

Even if some respondents were simply engaging in wishful thinking, these findings do reflect a growing public mood in favour of fundamental changes in sexual attitudes and behaviour. The norms of 'socially acceptable' sexual behaviour appear to be changing. High-risk sexual behaviour which, only four or five years ago, was widely tolerated or even accepted as the norm within many social groups, is now increasingly viewed as unacceptable.

There is ample anecdotal evidence for this shift in public attitudes and individual behaviour. Hotel staff in Kitwe and Ndola, the two main towns in the Copperbelt, report a sharp decline in the once-popular practice of people hiring rooms for casual sex during lunch-hours, public holidays and weekends. Participants in CHEP's AIDS seminars for 'blue collar' workers claim to have stopped 'picking up' girls in bars: "These days we just go to the bar for a drink and then go home to our wives."

Hotel and bar workers have told our fieldstaff, however, that it is only the

older, married men who have changed their behaviour. Many men and women in their late teens and early twenties, especially if unmarried, continue to behave as if AIDS did not exist.

Condom use

Condom use is still not widespread in Zambia. The AIDSCOM study in the Copperbelt and Northern Provinces found that only 27% of people had ever used a condom, and only 8% had used one the last time they had sex. Condom use is, however, on the increase. Nationally, sales of condoms rose by an average of 20% annually between 1985 and 1990. Also in the Copperbelt, public demand for condoms has risen considerably in the past few years. Mr Alfred Mubanga, who until recently was the manager of a large pharmacy in Kitwe's town centre, reported sales of 12,000 condoms in the first quarter of 1992, which represented a 50% increase on sales in the same period in 1989.

Condoms are also included in the 'drug kits' supplied by the Ministry of Health to health centres, where they are distributed free of charge. Until two or three years ago, health workers in the Copperbelt reported that condoms would lie on the shelves, gathering dust, because of a lack of demand. These days, however, public demand for condoms is such that they are snapped up as soon as the drug kits arrive.

There is considerable evidence that increased public demand for condoms is motivated mainly by growing awareness of the need for protection against disease. The AIDSCOM study, for example, found that 70% of respondents associated condoms with protection against diseases (including AIDS), and only 28% with avoidance of pregnancy.

The supply of condoms to pharmacies and health centres, however, is erratic because all stocks have to be imported into the country. This sometimes results in pharmacies and health centres running out of stocks long before fresh supplies are received.

Sexually transmitted diseases (STDs)

There have not yet been any studies of the level of HIV prevalence in the general population of the Copperbelt, which is the area where CHEP's efforts are concentrated. However, since studies in

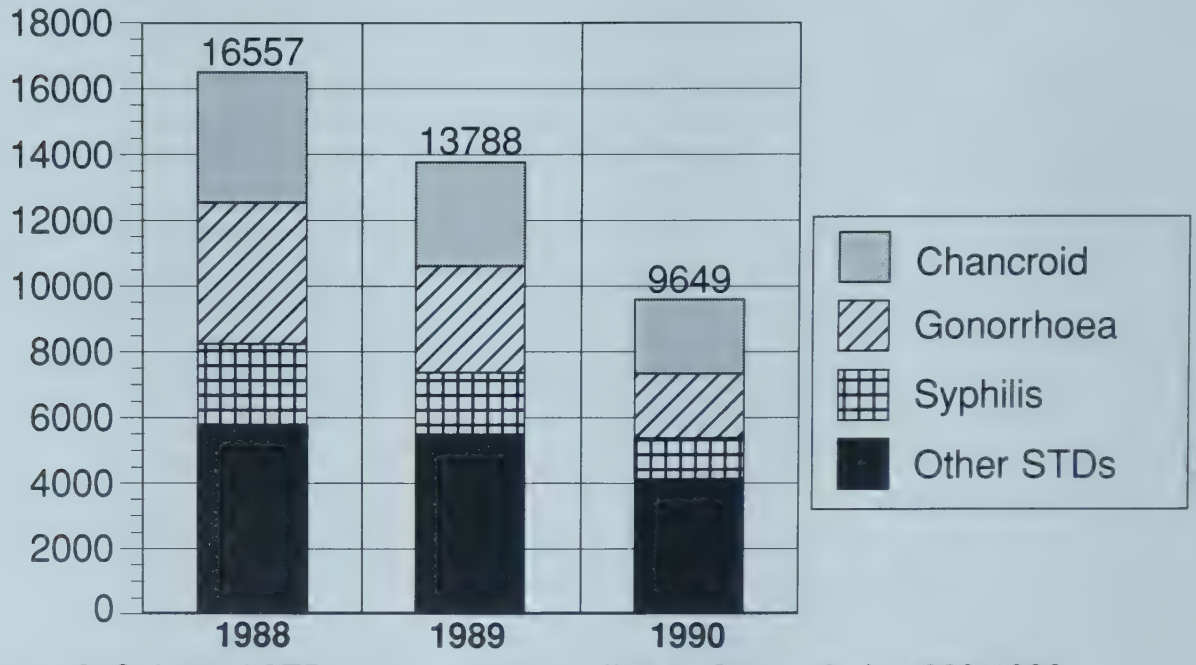


Figure 2: Selected STDs treated at four clinics, Copperbelt, 1988-1990

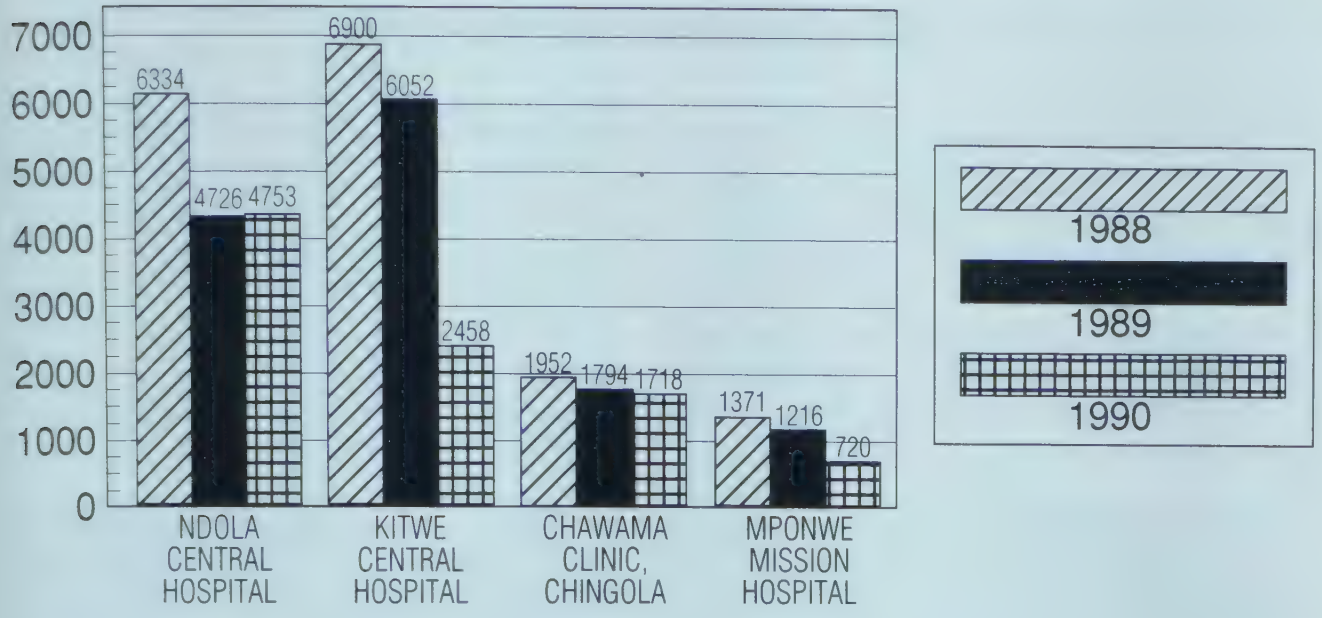


Figure 3: All STDs treated at four clinics, Copperbelt, 1988-1990

Zambia show that 30-50% of STD patients are also infected with HIV[13], the incidence of STDs can also be used as a 'proxy' indicator of the spread of HIV infection within the population.

In recent years there has been a remarkable decline in the number of new STD cases treated at Ministry of Health and mission hospital clinics in the Copperbelt. Between 1988 and 1990, cases of syphilis, gonorrhoea and chancroid treated at four STD clinics (three in urban areas, one in a rural area) in the Copperbelt have declined by 54%, 53% and 42% respectively (see Figure 2). Overall, the total number of STDs treated by these clinics fell by 41% during the same period (see Figure 3).

Doctors working in private practice also report a decline in the number of patients coming to their clinics to be treated for STDs. Dr Mahendra Vaidya, a General Practitioner working in Kitwe, reports that the number of new STD patients coming to his clinic has declined sharply from about 20 cases a day in 1988 to about 5 a day in the first few months of 1992. (At the same time, the number of new patients coming for treatment for other diseases has remained constant, at about 60-80 per day.) However, Dr Vaidya also reports a disturbing new trend. In the past, over half of his STD patients were aged 35 years and over. These days, however, 75% of new STD cases are in the 18-25 year old age group. This suggests that, although many older people have changed their sexual behaviour, many young people are still reluctant to do so. This has important implications for the future direction of AIDS prevention programmes.

We believe that the marked decline in numbers of new STD patients in the Copperbelt in recent years indicates that many people are taking steps to protect themselves from AIDS and other sexually transmitted diseases. For some, this means avoiding sex outside of a mutually faithful relationship. For others, it means using a condom for casual sexual encounters. Both these behaviours reflect a heightened awareness of the need for the individual to take personal responsibility for his or her sexual behaviour. We believe that CHEP has made, and continues to make, a significant contribution to bringing about and sustaining these important changes in attitudes and behaviour, which are helping to curb the spread of HIV and AIDS.

15. Future directions

CHEP will continue to follow a multi-pronged approach to AIDS prevention, using mass media, small media and interpersonal means of communication to reach a wide variety of specific target groups. New priorities, however, have emerged and are leading CHEP into important new areas of programme development, in particular:

● **Women**: A recent CHEP evaluation revealed that the great majority of participants in our seminars and workshops have been men. Even when women were present they were usually in a minority and only very few felt able, in the presence of men, to express their thoughts and feelings, especially on sensitive topics such as sexual behaviour

CHEP's plans for the future include more emphasis on the training of women, so they are better equipped to control their own lives and educate their children about AIDS.

CHEP is therefore organizing educational sessions on AIDS specifically for groups of women, so they can take greater control of their own lives and also educate their children about AIDS. As most women are already overburdened with work and family responsibilities, these sessions are being organized to fit in with the occasions when women already gather together in groups. These include, for example, health clinics, women's clubs and women's trade unions. Some sessions will be run by full-time CHEP staff, others by part-timers from our Outreach Team, and others by local people trained by CHEP for this purpose.

● **Girls**: CHEP will also focus special attention on out-of-school girls, who urgently need to find ways of earning a regular income in order to avoid sexual exploitation and the risk of HIV infection. In the first few months of 1992, CHEP organized three five-day 'crash courses' in survival skills for groups of 20-25 girls, and these will continue on a regular basis.

● **AIDS orphans**: As people already infected with HIV develop AIDS and die, the number of AIDS orphans will increase during the 1990s. Such children are themselves at high risk of sexual exploitation and infection with HIV. With the capacity of the extended family system for coping with orphans seriously weakened, communities need to develop new ways of caring for and supporting orphans. CHEP has already started seminars for parents who are interested in 'fostering' orphans. In one Copperbelt township, 14 such couples are already caring for orphans, who continue living as a family unit in their own home rather than in the home of their 'foster' parents, who live nearby.

● **Schools**: Another important area of programme development for CHEP will be the integration of education about sexuality and human relationships into the curriculum, for both girls and boys, at all levels of the education system. Because sexuality is such a sensitive issue, surrounded by many traditional beliefs and taboos, it will be necessary to work not only with teachers, but with parents and community leaders as well. CHEP will also forge closer working links with the Child-to-Child programme and Anti AIDS Clubs, which are already active in several schools in the Copperbelt.

CHEP will continue to develop in response to changing needs and emerging opportunities in the years ahead. Ongoing monitoring and evaluation will highlight areas of strength and weakness, leading to changes in programme strategy and management. Surveys will identify new target groups in need of particular attention. Inevitably, the organization will experience some growing pains, but these will be faced and overcome with the same commitment, creativity and good humour as in the past.

GLOSSARY

AIDS: Acquired immune deficiency syndrome.

Baseline data: information collected before the start of a programme to evaluate the impact or outcome of the programme.

Blood donor: a person who donates blood for medical purposes. (In Zambia all blood donation is done on a strictly voluntary basis.)

Channel of communication: way in which a message is transmitted (e.g. word of mouth, radio, newspaper, music, theatre).

Communication: the transfer of information (including ideas, emotions, knowledge and skills) from one person (or persons) to another (or others).

Communication materials: products such as radio spots, flip charts, posters and training manuals, used to convey messages to particular audiences.

Evaluation: the process of collecting and analysing information on the effectiveness of a programme.

Focus group: representatives (usually 6 to 12) of a target group who are asked prepared questions on a selected topic in order to obtain information to be used in designing messages and preparing communication materials.

Gatekeepers: people sharing common characteristics who influence the primary target group(s) and whose informed involvement is necessary to support them.

High-risk sexual behaviour: unprotected vaginal, anal, or oral sex with anyone other than a partner who is known to be faithful and uninfected.

HIV: Human immunodeficiency virus, the virus which leads to AIDS.

HIV/AIDS counselling: a helping relationship between the client (or patient) and the counsellor, with the aims of: (a) providing psycho-social support to persons already infected with HIV and (b) preventing further transmissior of HIV infection. The counsellor seeks to help people with HIV/AIDS to make informed decisions about their lives enhance their self-confidence, and improve the quality of their family and community relationships.

Interpersonal communication interaction between two or more people for communicating messages.

Knowledge, Attitudes and Practice (KAP) survey: systematic collection of information about the knowledge, attitudes, beliefs and behaviour of the target group(s) in relation to particular topics, e.g. sexual behaviour, nutritional habits, child care.

Mass media: major channels of public communication, especially radio, television and newspapers.

Message: the content of communication materials, or an idea (or set of ideas) to be communicated.

Primary target group: people sharing certain characteristics who are expected to adopt a recommended behaviour, or for whom certain services or products are intended.

Pre-testing: the process of testing communication messages and materials prior to their widespread dissemination, in order to improve their effectiveness.

Respondent: person who has been asked to respond to questions in a survey questionnaire.

Safer sexual behaviour: any form of sexual behaviour which minimizes the risk of HIV transmission. By far the safest is sex between partners who are mutually faithful and known to be uninfected. In all other situations a condom should always be used during sexual intercourse. The correct use of condoms provides a high degree of protection against HIV infection and

other sexually transmitted infections. Non-penetrative forms of sexual behaviour, such as dry kissing, cuddling, carressing, or massaging, in which the penis does not enter the vagina, the anus, or the mouth, carry no risk of transmitting HIV.

Sexually transmitted diseases (STDs): diseases transmitted through sexual activity, of which the most common in Zambia are gonorrhoea, syphilis and chancroid.

Small media: small-scale channels of communication such as pamphlets, booklets, posters, flip charts, slides and videos.

Target group: persons whose knowledge, attitudes and behaviour are to be influenced by the messages and communication materials.

MATERIALS AVAILABLE FROM CHEP

The following materials are available free of charge from the Copperbelt Health Education Project (CHEP), P.O. Box 23567, Kitwe, Zambia:

Booklets

Information on AIDS for Adult Men and Women (20 pages)

Living With HIV and AIDS (20 pages)

Talking AIDS. A Guide for Community Work (42 pages)

What Everyone Should Know about STD (12 pages)

Leaflets

AIDS and the Work Place

First Aid and AIDS

How to Use Condoms

What Medical Staff Need to Know about Condoms

What Everyone Should Know about TB

Posters

"Smart girls say NO to sex before marriage"

"Smart guys say NO to casual sex"

"I use a condom every time..."

"I want to protect my family from AIDS"

"Protect yourself and your patients" (infection control guidelines for hospitals)

"STD Management Guidelines" (for clinicians)

FURTHER READING

1. **'AIDS Action'**, an international newsletter for information exchange on AIDS prevention and control. Distributed free to readers in developing countries. Available from AHRTAG, 1 London Bridge Road, London SE1 9SG, U.K.

2. **'AIDS Newsletter'**, a digest of recent developments in AIDS research, education, clinical care, counselling, and official policies worldwide. Available from the Bureau of Hygiene and Tropical Diseases, Keppel Street, London WC1E 7HT, U.K.

3. Geoff Foster, **Living Through AIDS**, 1990. Available from the Family AIDS Caring Trust, 107 Main Street, Mutare, Zimbabwe.

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7. Gill Gordon, **AIDS and Family Planning**, flannelgraph and book, Teaching Aids at Low Cost (TALC), 1988. Available from TALC, P.O. Box 49, St Albans, Herts AL1 4AX, U.K.

8. Marie-Thérèse Feuerstein, **Partners in Evaluation**, Macmillan, London, 1986. Available from TALC.

9. Wendy Holmes and Felicity Savage **HIV Infection – Virology and Transmission**, slide set and script TALC, 1989.

10. Wendy Holmes and Felicity Savage **HIV Infection – Clinical Manifestations,** slide set and script TALC, 1988.

11. Wendy Holmes, Felicity Savage and John Hubley, **HIV Infection - Prevention and Health Education**, slide set and script, TALC, 1989.

12. John Hubley and Felicity Savage, **HIV Infection in Children**, slide set and script, TALC, 1992.

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Geneva, 1990. Available from World Council of Churches, 150 Route de Ferney, P.O. Box 2100, 1211 Geneva 2, Switzerland.

19. **'World Health'**, November-December 1990. Available from World Health Organization, 1211 Geneva 26, Switzerland.

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VIDEOS

TASO: Living Positively with AIDS (55 minutes). A two-part videotape on the work of the AIDS Support Organization (TASO) in Uganda.

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